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## Original Lectures.

CLINICAL LECTURE ON  
"PERINEAL SECTION" AND SYME'S OPERA-  
TION OF EXTERNAL URETHROTOMY.

DELIVERED AT THE NEW YORK HOSPITAL.

BY THOMAS M. MARKOE, M.D.,

ATTENDING SURGEON.

I have asked you to meet me in the theatre to-day, gentlemen, because, during the past few months, you have seen in the wards a number of cases of operation for stricture and its consequences, to which I wished to direct your attention, as it were "en resumé." These operations are of two different kinds, each having different indications, and having a different surgical significance, and to these differences, as well as to their points of resemblance, I have thought that our study this morning might be profitably directed.

No surgeon who has had much experience in the management of strictures can fail to have encountered some cases which were entirely rebellious to treatment. The reasons of this intractability I do not now propose to dwell upon; but the fact is one fully recognised by practical men, that there are a certain number of strictures which will not yield to dilatation, caustics, or internal incision, or if they do so yield, it is only for a time, the disease returning in all its severity as soon as active treatment is laid aside. Still further these cases are, of course, liable to become complicated with any of the various accidents to which stricture patients are exposed; and to a stricture thus rebellious to all treatment, we may have superadded, a retention of urine, a perineal abscess, or an extravasation of urine, which adds to a case already difficult, an element of serious danger to life.

It is not wonderful that surgeons, in such cases, have been led to look to the knife to extricate their patients from so serious a condition. Accordingly we find that two hundred years ago, there is a record of a case, in which despairing of relief from ordinary plans of treatment, the surgeon was induced to puncture the bladder through the perineum, to release his patient from impending death. Many other isolated cases are scattered over the records up to the present time, but the cutting operation through the perineum for the relief and cure of stricture, can hardly be regarded as a recognised operation until the present century. I do not know that any particular name is associated with this operation as its inventor, nor indeed that any of the great men who have employed it claim to have perfected its details. It seems to have gradually forced itself on the profession, as a resource in certain otherwise desperate cases; and has always been looked upon as an undesirable, an unsatisfactory, and uncertain, though sometimes a necessary surgical expedient. Perhaps in glancing thus at the history of the operation, the name of John Hunter should not be omitted, he being one of the earliest English surgeons who countenanced or practised it. He first operated by opening the urethra behind the stricture, and pushing a trocar through the contracted portion to meet his opening behind. This operation which, of course, can have but a limited application, he afterwards extended to the usual incisions in perineo. Since his time most of the great surgeons have resorted to the operation, and most of the distinguished writers have given it a place in their works as an accepted surgical expedient.

The operation is technically called the *perineal section*, and I may as well here define what is meant by that term. It is applied to those cases, in which the surgeon, not being able to pass any instrument through the urethra, into the bladder, has therefore no guide in cutting through the stric-

ture, but his knowledge of the anatomical relations of the parts. This is also called the *bouttonnière*, or button-hole operation, by the French writers, because the incisions make a sort of button hole between the skin of the perineum and the urethra.

Having thus glanced at the nature of the operation and its history, let me ask your attention to the cases in which its performance is indicated. In the first place, then, I would premise that, by its very definition, it is confined to those cases in which an instrument cannot be passed through the stricture. I do not propose, at this point, to enter into any discussion of the question of the impermeability of strictures. It is sufficient for our purpose, that there are many cases in which, at the time of operation, an instrument cannot be made to pass; and it is this which makes the distinction between the perineal section, and another operation, in which the stricture is divided on a guide, previously passed through it, which latter procedure is a modern proposal, and as it was introduced by Mr. Syme of Edinburgh, has been called by his name. In order to contrast more strikingly these two operations, I have written this table, which is intended to show the different circumstances which, in the various forms of stricture, indicate one or the other as the most proper to be performed.

## PERINEAL SECTION.

1. Retention of Urine.
2. Extravasation of Urine.
3. Perineal Fistula.
4. Impassable stricture.

## SYME'S OPERATION.

1. Contractile stricture.
2. Irritable urethra.
3. Extensive stricture.
4. Traumatic stricture.

1st. *Retention of Urine* complicating a close stricture is a very common circumstance, and can generally be relieved by appropriate general remedies, together with careful and gentle use of small bougies, as you saw us do in Ratz's case, who was the last one before us in this condition. Sometimes, however, we do not succeed in procuring relief, and the over-distended bladder demands immediate emptying. In this emergency we have several courses open to us. We may tap the bladder through an incision made above the pubes; we may tap it more safely and more conveniently, by a long curved trocar introduced through the rectum after the method so ably advocated by Mr. Cook of the St. Bartholomews Hospital; or lastly, we may perform the perineal section, in doing which we may most commonly have the satisfaction of curing at the same time the retention and the stricture. The hope of obtaining this double result makes this operation eminently suitable in most of these cases, and it was for this condition that most of the earlier operations of perineal section were performed; and I may mention in passing, that cases of retention are generally easier to manage by this operation, because the urethra, distended behind the stricture by the accumulated urine, offers a sort of guide in searching for the track into the bladder, which is entirely wanting when the operation is performed for other conditions.

2d. *Extravasation of Urine*.—This accident, as you know, demands in all cases, and as promptly as possible, deep and free incisions into the parts which are invaded by the urine. Now, as in most instances it is the perineum which is the seat of the effusion, we have again a double indication for performing the perineal section, inasmuch as the incision we make for the purpose of reaching the stricture is serviceable in giving vent to the extravasated urine. This unfortunate accident is one which very frequently demands operative interference, because the inflammation and swelling which the urine causes in the tissues outside of the urethra, are apt to close up the passage of a close stricture, so that no instrument can be got through, and an operation without a guide is our only resource. I said that the operation when performed for retention was comparatively easy; when performed for extravasation, on the other hand, it is often, from the confusion of parts and tissues, by the inflammation and sloughing, produced by the contact of the urine, a blind groping, in which the only thing we have to guide us is our know-

ledge of the position which the urethra ought to occupy in relation to the bony prominences in its neighborhood.

**3d. Perineal Fistula.**—The very existence of these fistulae indicates a grave and advanced degree of stricture, and a condition of parts unfavorable to cure by ordinary methods. Still further, these fistulae themselves require the same treatment which fistulae are so apt to require in other parts of the body, viz. an incision which shall lay them open freely towards the nearest natural surface. The operation therefore of perineal section seems particularly indicated in these cases, and, in fact, I very much doubt whether dilatation of the stricture, be it ever so complete, would often be successful in healing up the perineal fistulae, particularly if they were old and numerous.

**4th. Impassable Stricture.**—If we have a case which is absolutely impassable, then it is evident that the perineal section is our only resource. With regard to this matter of impassable strictures, there has been a vast deal of unnecessary controversy. Probably some of you can remember, a few years ago, how severely Mr. Syme was handled on both sides of the Atlantic, for having asserted, as it was said, that there was no such thing as an impermeable stricture. Now, in fact, Mr. Syme never did say that there was no such thing as an impassable stricture, but he made some pretty strong expressions as to its extreme rarity in his own practice, which subsequent experience obliged him to explain and to modify. The controversy which thus originated was nevertheless bitter and acrimonious in the extreme, but it has had one good effect; it has made men watch and sift their experience with great care, and it has thus brought out the great fact, which is the one of practical importance to us, that where we have time to wait and where there is no morbid irritability of the urethra, we can, by patient, careful, and repeated efforts, finally succeed in introducing an instrument, through the closest strictures, in so large a proportion of cases, as to show that Mr. Syme was not far wrong in the strong statements which he originally made on this subject. Making all due allowance for this fact, however, I do contend that, in actual practice, we occasionally meet with cases where, from want of time or from other causes, we cannot introduce any instrument to serve as a guide for our incisions. I do not now allude to those rare cases where, from traumatic causes, the canal is entirely obliterated. In all these cases, therefore, of impassable stricture, where the condition of things is such that delay would be hazardous, the perineal section is indicated.

To these four, perhaps I should add another class of cases indicating this operation, viz. those in which false passages exist, which turn aside the point of our instrument, be it large or small, so that we are unable to find the opening of the urethra, which, if it could be found, would perhaps be large enough to receive a good-sized instrument. A very large proportion of the cases of close stricture received in this institution, are complicated with false passages. Unskilful persons, and those not accustomed to appreciate the amount of force which the urethral membrane will bear, are exceedingly apt, in their anxiety to surmount the obstruction which they encounter, to use such a degree of pressure with the point of the instrument, as to force it through the mucous membrane of the canal, into the areolar tissue outside. This tissue being loose and lacerable, allows the instrument to travel through it without much difficulty, and the operator, finding that he has passed the point of obstruction, congratulates himself that he has got his instrument through the stricture, and does not discover his mistake, until the end of the catheter is stopped by coming in contact with the prostate gland, or the side of the bladder, and no water flows through it. This accident certainly is due, in most instances, to want of skill or want of care and gentleness on the part of the operator; but, gentlemen, let me caution you not to imagine that, with all the skill and knowledge you may possess, you may not yourself do the very thing which we are condemning. You must remember that the mucous membrane around a stricture is apt to be more or less softened from inflammation, and that in this

condition a very slight pressure, particularly with the point of a small metallic instrument, will perforate the softened membrane, and we may thus, any of us, produce a false passage when we little expect it, and with a degree of force which we did not suppose sufficient to cause the mischief. The true safeguard against this accident is to have the possibility of its occurrence always before you, and this will generate a care, and deliberation, and delicacy, in your manipulations, which, if you have a proper knowledge of the anatomy of parts you are working on, will pretty certainly preserve you from the apprehended danger. For myself, so great do I regard the risk of inflicting injury on the urethra by the use of small silver or steel instruments, that I have for years abandoned their use almost entirely, and now depend upon the flexible bougies and catheters, in all cases of close stricture, during the earliest stages of treatment, when small pointed instruments are necessarily used. I am happy to say that in using the fine conical instruments made by the French I have had every reason to be satisfied, and I believe this would be the testimony of most of my colleagues in this Hospital.

Having thus glanced briefly at the classes of cases which require the operation of perineal section, let me now give you an account of the operation itself. The perineum being shaved and cleansed, and the bowels well evacuated, the operation is generally best performed with a bladder moderately full of urine, the flow of which may serve in some degree as a guide to the end of the urethra in the wound, and be the evidence on the completion of the operation, that we have reached the bladder with our instruments. A full-sized grooved staff should be passed down to the stricture, and held by an assistant steadily against it. An incision should now be made along the median line of the perineum, and its position and extent regulated by the depth of perineum and the situation of the stricture. We cut carefully in the median line, because you know no large vessels cross that line, and we therefore avoid, in a great degree, the danger of hemorrhage. Having carried our incision down to the staff which can be felt in the urethra, this canal is to be opened a little in front of the stricture, by an opening which should be large enough to give you a full view of the interior of the mucous canal, and, if possible, of the anterior face of the stricture. In order to get this full view of the stricture, it is necessary to have the cut edges of the open urethra drawn forwards towards the surface, and at the same time drawn apart, so as to open the wound as wide as may be. This may be done by fine hooks, or more conveniently by threads passed by a curved needle through the cut edges of the urethra. These threads, which you saw me use in the case of White, are very convenient, are not in the way of your instruments, and very much facilitate the further steps of the operation. Having opened the urethra, one of two conditions may present itself. *First*, in a certain number of cases having the anterior face of the stricture directly under the eye, we can succeed in passing a probe or director through the stricture; or *second*, with all care we may not be able to introduce the smallest instrument past the obstruction. If the first condition obtains, and we are fortunate enough to get anything through the stricture, the further steps of the operation are simple and easy enough. We have only to divide the constricted portion of the urethra on this instrument, and the cutting part of the operation is done. If, on the other hand, we cannot get any instrument to pass, and I am sorry to say that it is the most common condition of these cases, we have to work along with a small pointed sharp knife in the direction of the urethra, cutting as little as may be, and constantly searching with a probe for the urethra behind the stricture. And here, gentlemen, commences the difficulty of the operation. You can easily see that at best it is a groping in the dark, and when the parts are thickened and altered by inflammation there is no operation in surgery more tedious or more difficult. If the strictured part of the canal is short, and the surrounding parts not much diseased, by a little careful dissection we can usually divide the stric-

ture and reach the sound urethra behind it, and this is much facilitated by the urine pressing forward and distending the canal. But if the strictured part be extensive, and the surrounding parts much altered, then it must be acknowledged there can be no certainty or precision in the dissection. It is truly an exploring expedition, and the most important qualification for it is an inexhaustible stock of patient perseverance. Sometimes the knife wanders by the side of the stricture and reaches the urethra beyond without having divided the stricture at all. This we cannot always appreciate in the altered condition of the tissues, and we may think ourselves fortunate if we have made a short and direct communication between the two divisions of the urethra, and whether we have laid open the stricture or gone by the side of it we often have no means of knowing, and fortunately no reason to suppose that it will make any material difference in the final result. Having established a communication between the urethra behind and before the stricture, all that remains is for us to pass a full-sized catheter along the whole canal, and tie it with tapes so that it shall not slip out from the bladder. The after treatment consists in keeping the catheter in the bladder for a length of time which should vary according to the case. If your incisions have been extensive and a wide space has intervened between the two portions of the urethra and particularly if you fear that the incisions have passed round rather than through the stricture, then the catheter had better be allowed to remain a week or ten days, changing and cleaning it at intervals, in order to mould round the granulations which spring up to form the new portion of the canal. If, on the other hand, you have had to cut but little in going through the stricture, so that there is but little new urethra to be formed by granulation, then it is not best to leave the instrument in more than two or three days. In either case, however, it should be introduced daily for a time, and in fact as often and for as long a period as may be necessary to prevent a recontraction of the divided stricture.

(To be continued.)

PUBLIC HYGIENE instructs man how to remove from his midst the prolific sources of disease; to level the thick forest which intervenes between his homestead and the free passage of the purifying breeze, and the access of the genial rays of the sun; to drain or fill up reeking swamps and festering pools; to cleanse foul and fetid sewers and cesspools, and the proper system of drainage and sewerage for large cities; to build barracks and hospitals in salubrious localities; to remove bodies of troops from those which are not so, to others that are, thus greatly diminishing the mortality of armies and the expenditures of governments; to oppose the lazaretto and the quarantine to the introduction of pestiferous effluvia; to purify the infected holds of ships; to cleanse the interiors of foul and filthy dwellings, and to separate their over-crowded masses of disease-producing inhabitants, and so to build tenant-houses, as to secure alike the health and comfort of their inmates. It teaches him how to effect the ventilation of all buildings destined for the reception of large concourses of individuals—prisons, churches, theatres, public schools, lecture-rooms and halls of legislation. It secures for the interior of hospitals, that necessary supply of pure air, which assures their inmates against the prevalence of those terrible scourges, hospital typhus, dysentery, erysipelas, gangrene and puerperal fever, which have from time to time produced in those institutions such an amount of mortality, as has caused it to be gravely debated whether hospitals were not, upon the whole, a greater curse than blessing to the poor. It removes from wards and other places, into which they had obtained access, all malarious influences, by means of suitable ventilation, cleanliness and disinfecting agencies.—*Dr. W. C. Roberts' Eulogium of Medical Science.*

## Original Communications.

### DYSPPNEA AS A MECHANICAL CAUSE OF CONGESTION OF THE LUNGS.

BEING AN

ABSTRACT OF ONE OF A SERIES OF LECTURES ON "DYSPPNEA,"

Delivered at the College of Physicians and Surgeons, during the Spring Course of 1860.

BY ANDREW H. SMITH, M.D.

It has long been known that severe or protracted dyspnea gives rise to a greater or less degree of congestion of the lungs, and various theories have been proposed from time to time, to explain this result. Haller supposed that the impeded play of the lungs presented a mechanical obstacle to a free circulation of the blood through those organs, and hence an accumulation in the pulmonary vessels. (a) Dr. Goodwyn (b) maintained that the imperfectly aerated blood did not afford the necessary stimulus to the left side of the heart; that therefore the left chambers contracting feebly, emptied themselves imperfectly, and the blood set back into the lungs. Bichat(c), again, supposed that the circulation of venous blood through the substance of the heart, produced a more or less perfect paralysis of that organ, increased by the depressed condition of the nervous system, and that the blood stagnated in the lungs, as in the systemic circulation, from a deficiency in the propulsive force. This view continued to be held for a long time, until the publication of Dr. Kay's work on asphyxia, in 1834, introduced a new theory, which is the one generally held at the present time. Dr. Kay shows that the obstruction begins in the lungs, and attributes it to the chemical condition of the blood, which he conceives to be such as to prevent its circulation through the minute pulmonary capillaries. He says: "The laws generally observed to regulate the action of the small vessels in other structures would be violated if the vessels which usually carry arterial blood, were also able to convey, with equal facility, venous blood in every stage of its changes until it acquires its darkest color." And again: "When venous blood enters those vessels which formerly conveyed arterial blood only, this degenerated fluid is no longer able to excite their action, and the circulation stagnates in the structure of the lungs." (d)

In further elucidation of this theory, a species of "vital attraction" has been supposed to exist between the walls of the capillaries and the blood, by which the circulation was facilitated. This attraction, however, was supposed to be operative only in the case of arterial blood, and consequently to cease to act as soon as the blood assumed a venous character. (e)

More recently, Prof. Wintrich has advanced the opinion that the pulmonary congestion depended entirely upon the paralyzing effect, upon the heart, of the circulation of venous blood in the coronary vessels, and that the nerve-centres suffered no diminution of activity from the impure nature of the blood with which they were supplied. (f)

C. J. B. Williams(g) gives it as his opinion that at least the larger pulmonary vessels possess a contractile power, which is called into action upon the application of an unusual irritation. Such an irritation he supposes to be produced by the presence of non-arterialized blood, and the result is an obstruction of the circulation.

Now the degree of congestion capable of explanation by any or all of the foregoing theories, can be readily

(a) *Elementa Phys.*, lib. viii., sect. iv.

(b) *On the Connection of Life with Respiration*. London, 1788.

(c) *Recherches sur la Vie et la Mort*, p. 229 et seq.

(d) *Physiol. Pathol. and Treat. of Asphyxia*, pp. 20, 21.

(e) *Alison*.

(f) *Virchow's Handbuch der spec. Pathologie u. Therapie*, 5 Band.

1 Abtheil. p. 212 et seq.

(g) *Diseases of the Chest*, pp. 44, 50.



estimated by examining the lungs of an animal destroyed by section of the medulla oblongata. This operation produces an immediate cessation of the respiratory movements, and death by apnoea is the result. The action of the heart is in no way directly interfered with, and we have present, therefore, all the conditions for the production of congestion, which are contemplated in any of the above hypotheses. Were they sufficient to account for all the phenomena observed, we should expect to find in this case the maximum of congestion, or, at least, a degree of congestion equal to that produced by ligature of the trachea. But in reality a most striking difference is observed. In numerous instances in which I have performed this experiment, some degree of congestion was uniformly found when death was caused by section of the medulla, but it was insignificant when compared to that produced by occlusion of the trachea. The chemical condition of the blood must be the same in one case as in the other, and its effect upon the heart, lungs, etc., also the same. Therefore to account for the excess of congestion in the latter case, over that in the former, we are compelled to assume the existence of a cause of congestion, other than those given in the theories cited. This cause is to be found in the increased energy of the respiratory movements. In considering the mechanical part of respiration, we are apt to overlook the fact that there are two avenues of ingress into the lungs, one by the air passages for the air, and another by the blood vessels for the blood, and that the filling out of the space acquired within the thorax, by the expansion of its walls during inspiration is accomplished, not by one of these avenues to the exclusion of the other, but by both; that, in a word, we respire blood in precisely the same way, and by precisely the same mechanism as we respire air. The amount of blood drawn into the lungs in an ordinary inspiration is small, owing to the fact that the space acquired within the chest is readily filled out by air admitted through the trachea. But, obstruct the entrance of air, and at the same time increase the force of the inspiratory effort, and the amount of blood entering the lungs may be greatly increased. The atmospheric pressure upon the vessels within the thorax is rendered less than that upon the vessels of the body generally, and a rush of blood from every direction towards the thoracic cavity is the result. Hence it is evident that in every case of dyspnoea depending upon obstruction of the air passages, there must be a congested state of the lungs at the termination of every inspiratory effort. But is not this congestion relieved during expiration? In normal respiration, the quantity of blood drawn into the lungs, at each inspiration, is so small that it is readily expelled during expiration by the resiliency of the vessels, and by the pressure exerted upon them by the contracting tissue of the lung. Nevertheless, the blood, being a heavy, incompressible fluid, opposes a certain degree of resistance to this expelling force, and hence some little time is required for the complete removal of the temporary congestion. Under normal circumstances the interval between the inspirations is sufficient for this purpose. But in dyspnoea, in addition to the overloaded condition of the vessels, the interval between the inspirations is diminished. At the same time the effect upon the vessels of over distension, is an impairment of their tonicity. We have therefore three circumstances working together to produce an accumulation of blood in the lungs with each respiratory act. 1. The amount of blood to be expelled is increased. 2. There is less time allowed for its expulsion; and 3. The expelling force is diminished.

By means of the following experiment, I have been able to demonstrate, by a single operation, the difference between the degree of congestion resulting from non-aëration of the blood, and that produced by the additional effect of increased energy of the respiratory movements. A ligature was placed around the trachea of an animal, and drawn so tightly as to prevent completely the entrance of air into the lungs. At the same instant that the ligature was tightened, the thorax was freely opened on

one side, so that the air passed without obstruction in and out of the pleural cavity. By this means the influence of the respiratory movements upon the lung of that side was entirely suspended, while with respect to the other lung, it remained comparatively unimpaired. On examining the lungs after death, the one on the side which was opened was found to be but slightly congested, while the other was gorged with blood. The chemical condition of the blood must have been the same in both lungs, since both were equally excluded from the atmosphere. The effect of any change taking place in the action of the heart, or in the pulmonary vessels, must also have been the same in one lung as in the other, and we have therefore no other way of explaining the difference in the degree of congestion, than by ascribing it to the effect of the respiratory efforts, since this was the only influence to which both lungs were not equally exposed.

It would seem, therefore, that we are justified in considering it as a maxim that in every case in which the respiratory movements are increased to any considerable extent in force or frequency, there must be a proportionate degree of congestion of the lungs, as a *necessary mechanical result*. The importance of this fact can scarcely be over-estimated, since in nearly every pulmonary disease we may have dyspnoea, and, as a rule, pulmonary diseases are aggravated by congestion.

To illustrate the operation of this principle, let us take for example a case of bronchitis. At the outset of the disease, the bronchial mucous membrane is congested, its vessels turgid with blood. This condition implies a thickening of the membrane and a diminution of the calibre of the tubes, and hence an obstruction to the entrance of air into the lungs. At the same time the accompanying febrile movement quickens the circulation, and produces an increased demand upon the lungs. The respiratory movements become more frequent and forcible, and the expansion of the thorax not being responded to by a prompt and sufficient influx of air into the lungs, a compensating increase in the amount of blood flowing in is the consequence. The pulmonary vessels, already overloaded, receive a new supply, and their tonicity, already impaired by the effect of the disease, is still further diminished by this increased distension. With every increase of congestion, there follows an increase of obstruction and therefore of dyspnoea, which, in its turn, gives rise to a further increase of congestion. And so the process continues, the congestion aggravating the dyspnoea, and the dyspnoea aggravating the congestion, until finally the tension within the vessels arrives at such a point, that a serous effusion takes place into the bronchial tubes, mingling itself with the products of inflammation. By this means the tension is relieved, and the actual stasis which would otherwise result is avoided. But, if, as is often the case, the feebleness of the patient renders a sufficient expectoration impossible, or if the bronchial tubes, laboring under the disadvantage of having lost their ciliated epithelium, and of having their circular muscular fibres paralysed, cannot relieve themselves of the accumulating mass, then suffocation is inevitable, unless the process can be arrested by the intervention of art.

From the above considerations it follows that the success of any remedy employed for this purpose will be, to a great extent, in proportion to its influence, direct or indirect, upon the dyspnoea. The results in numerous experiments, which I have performed upon animals, and in a few cases where the same method has been tested upon the human subject, lead me to the belief that in cases in which the cause of the obstruction cannot be directly attacked, the most direct and certain means of relieving the dyspnoea, is by affording to the lungs an atmosphere which shall contain in the volume which finds access to the air cells, a quantity of oxygen equal to that respired in health. By this means the demand for oxygen is supplied, without the necessity for those violent muscular efforts which aggravate the cause of the dyspnoea, while at



the same time they exhaust the strength of the patient. With the necessary apparatus a sufficient supply of oxygen can be generated (at the bed-side) to continue the respiration indefinitely, and so far as my experiments extend made no danger whatever is to be apprehended from its use.

### A CASE OF FRACTURE OF BOTH FEMURS BY MUSCULAR SPASM.

BY FREDERIC D. LENTE, M.D.,

OF COLD SPRINGS, N. Y.

L. L.—, aged twelve years. This child, a boy, was in good health until he attained the age of fifteen months, when he was attacked with some cerebral affection that resulted in *epilepsy*, from which he has suffered to the present time. His affliction has been terrible. For the first year his seizures would recur about monthly, lasting several days, with intervals of from one to two hours between the paroxysms; subsequently they increased in frequency, and he has had as many as thirty or forty during the day, of a most violent character. They continued thus for some years, he being, during that time, under charge of my predecessor, Dr. A. L. Sands, now of New York. Sometimes there would be an interval of two or three weeks between the attacks, at other times they continued for days and weeks. For the past year or two, the intervals of exemption have become longer, generally about a month, but the attacks, when they do recur, are no less violent. The effect has been, of course, to destroy the intellect of the child, his power of speech, also his locomotive power to a considerable extent. There has been partial hemiplegia of the right side for some years. His appetite and digestion have been unimpaired during the whole of his sufferings, and his physical development has not been backward. Until a year or two ago he could stand upright, and could move about the room in a rapid, irregular manner, with assistance, using mostly the left leg; but, as he grew older and heavier, his feet became clubbed from relaxation of the ligaments, and for a long time he has not been able to stand at all; but he takes considerable exercise in his own way, throwing himself about in bed, and moving frequently from side to side, requiring constant watching. During his spasms he exerts considerable strength; in this way, his limbs, his upper ones especially, have preserved considerable muscular development. His parents are healthy, as are the other children, four in number. His convulsions are always of the *tonic* variety and very severe.

On April 10th, 1859, his spasms had been recurring every few minutes with great violence; during one of them, while he was held in bed by one of the family by the arms and shoulders, a number of others being in the room, a loud snap was heard by all present. It was thought that the hip "had slipped out of place," and upon examination by the parents, what they supposed to be an extensive swelling was perceived at the upper part of the left thigh. Upon being called in soon after, I recognised it at once as a fracture of the femur; its seat is the junction of the upper with the middle third of the bone. It is stated by the friends, that, at the instant of its occurrence, the thigh was flexed with great force, by the intensity of the spasm on the pelvis, and the fracture was evidently effected by the powerful action of the flexor muscles of the thigh. Assisted by Dr. Richardson, I administered ether, extended the limb, and applied a thick pasteboard splint to the thigh, carrying the bandage around the pelvis, the only idea being to secure union with the least possible inconvenience to the patient, with little regard to shortening.

June 1st.—Union of the fracture is firm, with considerable bowing and shortening, as was anticipated. A pasteboard splint encircling the thigh, and coated with a solution of shellac to prevent injury from urine and other fluids, is still kept on to prevent a repetition of the fracture, as he still has the convulsions.

Dec. 13th.—The right femur was fractured to-day in precisely the same manner as was the left. Put it up in the same manner. Jan. 29th.—Patient's health has been gradually failing since the occurrence of the last fracture, and to-day he died from gradual exhaustion. No attempt at union of the fracture has taken place. No autopsy could be procured.

Remarks.—I have been thus particular to cite the antecedent and attendant circumstances connected with this accident, because it is an extremely rare one. The occurrence of fracture from muscular exertion, or from the application of very slight force in cases of the cancerous and other diatheses affecting the integrity of the bony structures is not very uncommon; but in case of healthy bones (the *long* bones) the possibility of such an accident is positively denied by surgeons of note and authority. But Samuel Cooper cites a few instances which he considers authentic, and knew of one himself. In one instance it was the femur which was fractured, in the case of a cabin-boy, who attempted to maintain his balance on deck during the violent rolling of the vessel, and in making a powerful effort to do so, fractured this bone without falling to the deck at all.

In the present case there was no evidence of any unhealthy condition of the bones, and the brief history preceding the date of the fracture will serve to show that they were characterized by no unusual fragility, although smaller, no doubt than they should have been at the age of the patient, as were the muscles of the lower extremities also. What renders the case more remarkable, perhaps unique, in its character, is the fact that the bone was fractured during a tonic convulsion, that is by a steady pulling of the muscles, and not by a sudden jerk, as in the other recorded cases. His spasms were always of this kind both before and after.

July 10th, 1860.

### REPORT OF THE CASES OF FRACTURE OCCURRING IN PRIVATE PRACTICE,

WITH OBSERVATION UPON TREATMENT.

BY DAVID P. SMITH, A.M. M.D.

OF SPRINGFIELD, MASS.

In reviewing my professional business for the last six years and a half, my attention has been irresistibly drawn to the cases of fracture treated during that period. The mind naturally reverts to, and retains a vivid impression of, those cases which have occupied the most time and attention. I am of the opinion that much of the time was spent in attempts to obviate, by constant supervision, the inefficiency and awkwardness of machines erroneous in their original conception. The importance of this subject, and the desire of alleviating in some degree the sufferings of those meeting with this form of injury, are my only apologies for this article. Much of the apparatus now so sedulously urged upon the profession is Procrustean in conception and adaptation, and having suffered from them to a considerable extent, both in purse and patience, I have arrived at the conclusion that a great deal of ingenuity and application has been wasted for want of a proper appreciation of the objects to be gained. A brief survey of my cases, and as brief a statement of the conclusions drawn from them, will, I hope, interest without fatiguing the reader.

#### SEVEN CASES OF FRACTURE OF THE FEMUR.

Case 1.—March 25, 1853. Boy, set 8; fracture of right thigh at the junction of the upper and middle thirds; applied a modification of the double inclined plane; but, finding that his restlessness continually disturbed the bone, I changed it for the long splint, with one inner splint reaching from the perineum to the heel, enveloped in a splint-cloth. A short splint was placed in front, and also one behind the thigh. They being well padded, accurately

placed, and firmly bound on, so completely fixed the bone that he could roll around as he pleased without in the least disturbing the fracture. At the end of five weeks I removed the splints, and shortly after met him in the street walking without a trace of deformity.

**Case 2.**—Fracture of the neck of thigh-bone, occurring Jan. 12, 1854; presented nothing of interest except that persistence in getting the patient out of bed, after the end of a fortnight from the injury, although greatly against her will, and manifestly greatly to her discomfort, preserved her life. The limb never could be used.

**Case 3.**—Mr. C., Sept. 1, 1854. Sustained a fracture of the femur just above the knee-joint, and the tibia and fibula of same limb. The limb was placed upon a Goodwin's leg splint, and both fractures carefully adjusted, save a corner of the tibia which obstinately stuck up above its proper level. Finding the extending power of the splint insufficient I applied Jarvis's adjuster, and making strong extension the elevated point dropped into line. On the 3d I swung the splint from the ceiling, and he progressed rapidly; the fracture of the femur was firmly consolidated at the end of five weeks; but the union of the tibia was not completed until the end of ten weeks from the injury; thus showing that of two fractures in the same person one may unite much sooner than the other.

**Case 4.**—June 16, 1856. Mr. —, 83 years old, met with fracture of femur at junction of upper and second fourths; applied Desault's splint without expectation of union; at the end of a fortnight, finding him doing extremely well, and recognising the importance of enabling him to rise, I endeavored to apply a starch bandage. The fracture was so high up that I could not fix the upper fragment by the bandage, and was therefore obliged to let him remain in bed. The weather being very hot I feared much for the result. At the end of about six weeks the fracture had firmly united; but cholera morbus set in, and in his enfeebled state, he fell an easy victim, dying at the end of about seven weeks from the receipt of the injury. The femur was firmly united and did not yield even on the application of great force. I have no doubt his life might have been saved could I have put on a splint that would have allowed him to rise. In another such case I should either use the sole-leather splint, hereafter described, or Prof. N. R. Smith's anterior splint, with every expectation of a favorable result.

**Case 5.**—Fracture of neck of thigh-bone produced by tripping in a hem of the carpet; fracture probably occurred before the fall, as the old lady said she felt something give way before she fell.

**Case 6.**—Oct. 24, 1858. A young lady, at Mt. Holyoke Female Seminary, ran backwards off from the top of a stairway, and fractured her femur just above the condyles, the point of the upper fragment penetrated the skin about two inches above the patella. Dr. Kittredge, the resident physician, promptly reduced the displacement. Eighteen hours had elapsed when I saw her; knee greatly swollen and she suffered great pain; placed the limb upon a Goodwin's carved, double inclined-plane splint, and swung it from the ceiling inclining the cords forward so as to make all the extension that she would bear. I visited her again Nov. 2d, and found her doing well, but a dimple was plainly perceptible about three inches above the joint, produced no doubt by entanglement of the sharp extremity of the upper fragment in the fibres of the rectus muscle. I increased the obliquity of the cords so as to make more extension, and in order to prevent chafing under the knee; arranged the splint so that the leg from the knee down lay horizontally, while the thigh was at an angle of 45 degrees with the bed. Dec. 4. The angle of the splint had been gradually increased until now the limb was nearly straight; union had not yet taken place, for on bending the knee a little there was an evident rising of the lower end of the upper fragment. I now applied a starch bandage from the toes to the groin. A few days later, the attending physician, Dr. Kittredge, informed me that the bandage had been very long in

drying. We agreed to attach a cord to the foot, and passing that through a pulley, to make all the extension she could bear by suspending weights thereto; at the same time to apply a broad leather belt firmly around the seat of fracture. This dressing was continued until about thirteen weeks from the time of accident, when the union was firm enough to allow of carrying her home.

**REMARKS.**—In reflecting upon this case I have come to the following conclusions:—

1st.—That fractures, and especially compound fractures, of the condyles of the femur must, in order to procure the greatest comfort for the patient, be treated upon some form of the double inclined plane, and be swung from the ceiling or other point of suspension.

2d.—That sufficient extension can be made by attaching the foot to the foot-board by a broad strip of adhesive plaster extending from the knee down, around the foot-board, and up back to the knee upon the opposite side; and then inclining the suspending cords as far forwards as the patient will bear.

3d.—That sufficient counter extension can be made by raising the foot of the bed.

4th.—That the best method of preventing excoriation under the knee is to use "Watkins's Improved Splint," which is so arranged about the joint as to prevent undue pressure, and also to make the motions of the knee and splint exactly coincide.

**Case 7.**—Jan. 22, 1859. Mrs. W——, somewhat advanced in years, fell upon a plank walk, fracturing her right femur just below the trochanters; found her so short and corpulent that I despaired of being able to adapt any of the ordinary splints; applied, instead, upon the outside of the limb, from just above the crest of the ilium to a short distance below the heel, a piece of strong un-oiled sole leather, six inches broad, soaked in warm water; a similar piece was applied upon the inside of the limb, reaching from the perineum just below the heel. These soaked in warm water, and enveloped in two or three thicknesses of cotton cloth, I carefully fitted, fayed, and applied to the limb by means of a roller bandage. Around the pelvis and upper part of the thigh I took care to apply, very thoroughly, a firm spica bandage. The breadth of the splint at the lower end effectually prevented any inversion or eversion of the foot. In a few hours this casing became perfectly dry and as inflexible as sheet iron. It fitted as accurately as would a plaster cast; indeed when I removed it entirely, four weeks after the accident, there was not the slightest mark of unequal pressure to be found on the most careful examination.

**REMARKS.**—This mode of dressing, while it ensured perfect immobility of fractured surfaces, gave rise to no inconvenience to the patient. There was no galling, and consequently the irritative fever succeeding the fracture was of very short duration. At the end of four weeks I removed the splints, and at the end of six or seven weeks she began to get around on crutches. At the end of four months she had very good use of the limb. She now suffers but little inconvenience from it. There is one inch shortening. I am convinced that no other kind of dressing could have been retained upon the limb without great excoriation, for her skin and cellular tissue seemed as tender as those of an infant. I now keep prepared, and should apply a similar dressing to any fracture occurring about the head and neck of the femur in an elderly person. It might be well to attach a weight to the foot, by means of a cord passing over a pulley and fastened to adhesive straps as described, so as to keep up extension and counter-extension as long as it could be borne, or while the leather was hardening. It is proper also to remark that on one occasion, having applied these hide splints to a case of diseased knee-joint in a young lady, an eruption of a few days' duration appeared upon the skin, caused, as I think, by the moisture exuding from the leather. I always, therefore, take care to see that some dry cloth is placed between the skin and wet leather.

## SEVEN CASES OF FRACTURE OF TIBIA.

**Case 1.**—May 8, 1854. Mrs. G—— stepped upon a rolling stone and fell on the sidewalk; gave æther and examined the limb from the knee down, but could discover no fracture, although I was persuaded, by the intense pain referred to the shaft of the tibia, that there must be one. I placed the leg in a copper half-boot splint, after bandaging it carefully, and left it for two or three days; examining it again made out a fracture at the juncture of the middle with lower third.

**Case 2.**—June 11, 1854. Simple fracture of tibia in a child aged six.

**Case 3.**—May 2, 1854. Fracture of tibia of one leg and fibula of the other, both near the ankle, produced by the passage of an unloaded platform car over them. Great bruising of the soft parts, and delirium rendered the case rather critical, but under the use of gin and opium he gradually convalesced and soon gained perfect use of his limbs.

**Case 4.**—22d Oct. 1856. Mr. H—— met with oblique compound fracture of tibia. I used in this case Welch's and Seymour's double inclined plane splint, and also Jarvis's Adjuster; had great difficulty in keeping up sufficient extension to prevent protrusion of the end of the upper fragment through the skin. The angle of the splint had to be continually varied to relieve, as far as possible, its pressure under the knee; the discharge also accumulating in the splint under the limb caused great irritation. The counter-extending force was applied in turn to the knee, groin, and armpit; and in each was not well borne. Continual supervision and modifications of appliances were, in this case, the elements of success; union was firm at the end of nine weeks; one or two small pieces of bone were discharged about a fortnight after; limb was without deformity and of the normal length. I am confident that the apparatus I now use would have saved two-thirds of the drudgery in this case and been productive of as perfect a cure.

**Case 5.**—14th Aug. 1857. Mr. H——, an engineer on the Conn. Riv. R. Road, of perfectly temperate habits, about seven months previously, 7th January, 1857, suffered a severe compound fracture of the tibia, complicated with great bruising of the limb; large collections of matter formed among the muscles which necessitated extensive incisions; treatment, previous to the time I was called, was no doubt judicious—being conducted by men of acknowledged ability. At the time of my visit there were no evidences of the slightest union; ulcers on the inside and outside of the limb discharged pus; a large surface of bone was exposed at the bottom of each sore, and several pieces of dead bone had come away; amputation had been advised by the late Dr. Deane of Greenfield. My advice was:—1st. To give stimulants and tonics, as the patient was very pale and weak, although able to sit up. 2d. To put on firm splints, give him crutches and get him into the open air. My reasons for the advice I gave were these. The appearance of the limb and of the man betokened tardy union, or perhaps what would better express the entire want of any feeling of firmness in the limb, no union at all. I thought his long confinement to the house was calculated in the highest degree to encourage this state of things. It is difficult for me to convey any adequate idea of the entire mobility of the bones. It was much greater than is usual in recent fracture, probably in consequence of the want of tension in his muscles. Sept. 7. Found exactly the same state of things, except, perhaps, a little less discharge of pus; and again urged the same treatment; it was adopted, and in a week from this time he was about on his crutches; union commenced about two months after this and very gradually grew solid. He continued to visit me in my office until Dec. 1858. During this time small fragments of bone were extracted, and I made two or three attempts, by gouging off carious bone, to remove all disease; found I could not do this without breaking up the newly formed callus to such an extent as to endanger the integrity of the limb. After the union became firm there was another

struggle to call into action the wasted muscles, which from long disease and bandaging had degenerated. By long and steady perseverance this end was at length accomplished. Early in the spring of 1859 he was able to throw aside every artificial aid, and about the 1st of June, 1859, he went to work as engineer of a stationary engine.

I will quote a case nearly similar to this from a review of "Dr. Houston on Fractures," in the *Medico-Chirurgical Review* for April, 1836. The Dr. says, "The limb was now placed in the extended position; strong adhesive plaster was applied round the broken part, and some blue pill administered. A fortnight more elapsed—eight weeks from receipt of injury—and still the broken pieces admitted of motion on each other. At this period a new and unexpected affection showed itself, namely delirium tremens, in a paroxysm of which the man pulled off the splints and leaped out of bed. In the effort at standing the limb yielded to the weight of the body, and was a second time completely bent at the seat of fracture. Having recovered from the delirium, the patient was removed to his own residence for change of air, and then, when he began to hobble about on crutches, having the thigh well braced with plaster and bandage, the union of the fracture was, after a few months, accomplished."—Says the editor, "We believe that the cause of non-union in this case was quite independent of local management. The patient was accustomed to large amounts of stimulus. Dr. Houston is at pains to inform us that in the hospital stimulus was withheld. The constitution was called on to do hard work and it failed to do it. A man was under our care, as House-Surgeon of St. George's Hospital, on account of simple fracture of both bones of one leg. We laid the limb upon the side, on a splint, and made pressure by means of another side-splint and bandages; at the end of six weeks we found, to our surprise, that the union was so soft as to allow of flexion of the bones at the seat of fracture. We now inquired with more minuteness into the habits of the patient, and we found that he had been accustomed to drink several pots of porter daily. We had previously allowed him ordinary diet and a pint of porter. We now gave him three pints during the day, and put up the limb as before—ossific union rapidly ensued, and the patient was discharged cured in two or three weeks more.

A woman was received into the hospital with simple fracture of one leg, violent spasms of the leg ensued. To relieve these the house-surgeon bled her freely. She had previously been accustomed to a full diet and to porter, and the consequence of the depletion was much debility. The fracture did not unite, and although various means, among others the seton, and cutting down upon the fractured ends of bone, have been employed, the fracture continues ununited by osseous matter." The late Dr. J. K. Mitchell, in an examination on my thesis, asked me if I had ever thought of the plan of administering to patients, in whom false-joint threatened, large quantities of spirits so as to bring on a constitutional disposition to inflammation. I have quoted these authorities at length, and detailed my case in full, to show the steps by which I am led to the following conclusions:—

1st. I consider the failure of ossific union to arise from constitutional causes.

2d. A healthy, robust man, of perfectly temperate habits may, by long confinement to the house, and the drain of profuse suppuration, suffers from the absence of his accustomed fresh air, sun-light, and exercise, as a dram-drinker does from the absence of his toddy.

3d. At this period there is danger, not only that the patient will not improve, but that ligamentous union will occur requiring to be removed or destroyed by an operation.

(To be continued.)

A WRITER in the *London Medical Times* says, that Mr. Simpson uses annually, in his practice, no less than from five to seven gallons of chloroform.



## Reports of Hospitals.

### BELLEVUE HOSPITAL.

#### GANGRENE OF THE LUNGS.

GANGRENE of the lung, although a rare disease, is by no means so rare as Laennec, and some other writers would lead us to believe. One or more examples are almost always to be found in the wards of this hospital. The clinical history of the disease is, when it can be *clearly traced*, according to Dr. McCready, similar to the case detailed below, and by no means bears out the commonly received opinion that the gangrene is caused by pneumonia. On the contrary, gangrene occurs first and gives rise to the pneumonia, which is secondary to it. The notes of the following case were furnished us by Dr. ALEXANDER HADEN, House Physician.

Bridget Cannon, washerwoman, aged 48, native of Ireland, admitted to Bellevue Hospital, November 9th, 1859. She had no hereditary predisposition to disease, as far as could be ascertained; was not of strictly temperate habits; had been generally healthy up to the commencement of the present illness. Eighteen days before her admission to the hospital, while taking tea in the evening, without any preceding cough or appreciable thoracic difficulty, she was suddenly attacked with a distress in the right side, followed very soon by cough, highly offensive breath, and expectoration of matter disagreeable to the taste, of an offensive odor, of a dark color, and slightly mixed with blood.

On admission, she was quite exhausted, but not markedly reduced in flesh; cough continued, expectoration free, of a greenish color, and, as well as her breath, intolerably offensive. Her tongue was somewhat furred; the skin dry and feverish; pulse weak, about 96; bowels regular; respiration short and hurried. She complained of pain in right side on taking a full inspiration. On examination, pain was not much increased on pressure; no dullness could be discovered on *percussion* over any part of the chest, nor on auscultation any unnatural respiratory sound, except an occasional mucus rale. Dr. McCready examined the patient on the following day, but could discover, on careful physical exploration of the chest, no unnatural condition. He did not hesitate, however, to pronounce it a case of gangrene of the lung, from the peculiar odor of the breath, the character of expectoration and previous history. The diseased portion of the lung was thought to be central, occupying one of the lobes of the right side. The patient was placed on tonics, nourishing diet, and a small amount of stimulants. 17.—Respiratory murmur was noticed to be less complete in the scapular region, and dullness on percussion over the same. 18.—There were now undoubted signs of the formation of a cavity. Her pulse became more frequent, and her strength began to fail much more rapidly. 19.—Cavity was well marked in the scapular region. On the afternoon of the 20th she died; symptoms a short time before her death were not alarming; cough, expectoration, and offensive breath continued unchanged up to the time of death. *Autopsy twenty-four hours after death; body not emaciated; on opening the thorax, a large gangrenous cavity was found in the centre of the middle lobe of the right lung, involving also the lower portion of the upper lobe, and the upper portion of the lower lobe; no tubercles; other organs healthy.*

#### AMPUTATION AT THE ANKLE JOINT BY SYME'S METHOD.

Amputation at the ankle joint by the method first practiced by Mr. Syme, has been frequently performed in this Hospital, and with almost invariable success. The wounds have healed kindly, and left a firm cicatrix which has subsequently shown no disposition to ulcerate when subjected to the constant pressure of use. It has been remarked, in

nearly every instance, that the patient was able to leave his bed much earlier than in any other form of amputation of the lower extremity. In one instance a patient walked upon the stump on the fifteenth day, and thereafter continued to use the limb. The only instances of failure have been where the soft parts about the ankle and heel have been lacerated severely, as in railroad injuries, thereby resulting in sloughing.

This operation was recently performed by Dr. Parker. Before proceeding to the operation he took occasion to introduce to the class, a nurse in the hospital, whose left foot was amputated at the ankle joint, by Dr. Stephen Smith, upwards of two years ago. The stump was perfectly sound and healthy, and had never given her the slightest uneasiness. She now wears one of Palmer's artificial feet, and her movements have been so easy and natural, that many expressed surprise when she exhibited an artificial foot.

The advantages of this operation were briefly stated as follows:—1. The extremity of the stump is formed by the thick, callous integument of the heel, upon which the patient bears his weight with as much impunity as on the sound and healthy heel; and this he is able to do as soon as the wound is cicatrized. 2. The limb is but from one to two inches shorter than the other, and admits of the most perfect adaptation of an artificial foot, which so far remedies the defect of the limb that locomotion is as easy and graceful as before the operation.

Dr. Parker's patient rapidly recovered with a good stump. He was subsequently attacked with pulmonary tuberculosis, of which he died before leaving the hospital.

### NEW YORK HOSPITAL.

#### ANEURISM OF THE ARCH OF THE AORTA—RUPTURE INTO THE PERICARDIUM.

[Reported by JOHN C. ACHESON, Senior Assistant.]

The patient, George L—, æt. fort.-two, was admitted April 5th, 1860, during the service of Dr. J. H. Griscom, complaining of an intense pain in the cardiac region, and dyspnoea. The pulse was ninety, full, but somewhat irregular. He stated that about three months previous he had suffered from an intense pain in the cardiac region and right shoulder, accompanied with dyspnoea and palpitation. This attack had been followed by others of a like character, until, a week ago, when he was seized with one, which, as regarded the severity of the pain, was out of all proportion to any of the others—causing him to fall in the street in a partially insensible state. He was removed to a drug store near by, where he was relieved by the application of sinapisms to the cardiac region, and the internal administration of anodynes. The third day after this he was seized with another paroxysm which was similar, but less severe, and on the 5th of April he had a third, also slight in character, from which he was still suffering at the time of admission. On examination of the chest, a decided prominence of the precordium was noticed and the dullness in that region was very much increased in extent. Nothing abnormal could be detected in the heart or large vessels, with the exception that the sounds of the former were somewhat distant and indistinct. The patient never had syphilis, nor was he addicted to intemperance. The pain referred to was soon relieved by the administration of an anodyne, and the application to the part of a stramonium poultice. He continued, as far as the pain was concerned, in a comfortable condition for the next five or six days, during which time he suffered from a slight attack of jaundice, for which mercurials were given with a good effect. On the 11th of April, he was seized with another paroxysm of cardiac pain, which, however, was slight in character and soon subsided. The next day, while sitting quietly in his chair, he fell to the floor in a fainting-fit, from which he never recovered.



The autopsy was made fifteen hours after death. An aneurism the size of a man's fist, was found upon the ascending arch of the aorta, and just below the point where the pericardium was reflected from the vessel, a rupture three-fourths of an inch in extent had taken place. The pericardium was immensely distended with blood. The valves of the heart were healthy, but the organ itself was considerably enlarged, soft and fatty, while its surface, as well as the lining of the pericardium, was covered with a layer of old false membrane; atheromatous deposits existed all along the arch, but particularly around the seat of the aneurism. The liver was the seat of cirrhosis which was pretty far advanced. The kidneys were congested, but otherwise healthy. No disease was found in any other organ of the body.

#### RUPTURE OF STOMACH.

[Reported by R. F. WEIR, M.D., Resident Surgeon.]

A boy, aged fourteen, while flying a kite on the roof of a five-story building, having just before partaken of a hearty dinner, slipped and fell to the ground, a distance of about fifty feet, striking, in his descent, an intervening clothes-line, which broke under him. On admission into the Hospital, shortly afterwards, he was much prostrated, there was also considerable jaundice present, and great pain was experienced on pressure over the entire abdomen, which presented, across its lower portion, a transverse depression, but no abrasion or contusion. The patient did not rally, and died in about eleven hours after he first came under notice. The autopsy, twelve hours after death, revealed the existence of a rupture of the walls of the stomach, one and a half inches in length, with irregular lacerated edges and slight eversion of the mucous membrane, situated on its anterior surface a short distance from the pylorus, and running parallel to the long axis of the organ. The organ was, of course, collapsed. The intestines were moderately distended with gas, their peritoneal coats were much injected, and were covered with a thin layer of recent lymph. About two and a half quarts of turbid serum, plentifully mingled with shreds of corned beef and cabbage, in a slightly digested state, were found in the cavity of the peritoneum. No lesion of any other viscera nor of any of the adjacent bony parts was discovered.

#### NURSERY AND CHILD'S HOSPITAL.

##### ENTERO-COLITIS—CYANOSIS.

THE following case is interesting, on account of the sudden appearance of cyanosis, and the anatomical condition connected with it. The foramen ovale, the valves of the heart, and the ventricular septum presented the appearance usual in infants of one month, but the ductus arteriosus was sufficiently open to admit readily the end of the blow-pipe. Whether the perviousness of this duct was sufficient cause to produce the cyanosis, aided by the inflammatory condition of the system, may be uncertain, but some authors state this as a cause. The notes of the case were taken by Dr. Covell, Resident Physician.

June 9th, 1860.—W. H. McC— (under the care of Dr. ROBERT WATTS), died to-day, aged four weeks. He was nursed, and apparently in a thriving condition till within twenty-four hours of his death, when he was noticed to have diarrhoea, and a well-marked blue tinge of surface. His death occurred quietly, the cyanotic hue continuing till the last moment.

*Autopsy, fifteen hours after death.*—No emaciation; anterior fontanelle open; good resonance on both sides of the chest; the liver extends one inch below the lower margin of the ribs; weight of thymus gland two drachms; lungs healthy, and readily inflated; the ductus arteriosus open; at the foramen ovale is the usual valvular opening between

the auricles, but so oblique as probably to prevent any admixture of blood; weight of liver five ounces; stomach, jejunum, and upper part of ileum healthy; the mucous membrane of lower part of the ileum, and the entire colon, vascular, and that of the latter thickened; no ulcerations noticed; some of the mesenteric glands slightly enlarged, others natural.

*Microscopic Appearance.*—The blood contained an unusual amount of granular matter, but the blood discs and white corpuscles appeared to be in the usual proportion; the granular matter was mostly dissolved by ether. The hepatic cells contained few oil globules, and there was less free fatty matter in the liver than is commonly found.

#### NORTHERN DISPENSARY.

##### CASE OF INTERMITTENT LIMITED TO ONE HAND AND ARM.

The subject of this attack, was a married woman, aged thirty-four, mother of five children, all of whom died while infants, of various diseases. She was native of a healthy place in Ireland, and has always lived in her present neighborhood, since coming to this country five years ago. She is healthy and robust, and always attends to her own household duties, has lived in an upper room until eight months ago, when she entered a dry, airy basement.

About the first of June she whitewashed her room, and was engaged three days, working at intervals. Her right hand and arm often felt fatigued and cramped, but was relieved on resting. After completing her white-washing, her hand and arm continued to pain her at intervals, and she was particularly distressed by a creeping, and prickling sensation as if the limb were asleep. On the third day after white-washing, these symptoms assumed a periodic form. She awoke soon after midnight with complete numbness of the right arm extending to the elbow. The arm felt several times its natural size, was hot, had not the slightest sensation in it, and was the seat of a severe aching pain. She used friction, a bath of hot mustard water, &c., and in about an hour sensation began to return in the upper part of the arm, and gradually passed down to the hand and fingers, the tips of which were the last to regain their normal feeling. This was followed by a general sweat, lassitude, and sleep. At four o'clock of the same morning she awoke again with the same condition of the arm, and went through the same process of using friction and warmth, and with the same results.

For three weeks following, these attacks recurred with the utmost regularity at twelve o'clock at night, and four o'clock in the morning, always commencing with a tingling, or pinching, in the ends of the fingers. This gradually extended up the limb, followed by complete numbness, but never passed above the elbow. The arm during this time became hot, and the whole body feverish, but there never was a chill, local or general. The only change in these attacks which was noticed during this period was a slight lengthening of the paroxysm. Her health suffered but little, though she felt more languid than usual. She had not seen any case of intermittent fever during the year in her neighborhood. It had been treated as a case of paralysis, but with no benefit.

Regarding it as an irregular form of intermittent fever, quinine was administered, one grain every two hours; on the fourth day, she reported herself cured. She stated that during the first day she took the medicine regularly, and at night the numbness extended up to the middle of the forearm; on the following morning it only involved the hand; she continued the remedy during the next day, and at night it reached the middle of the hand, and in the morning it appeared in the little and ring finger; on the following night it involved only the ends of the fingers, and in the morning she merely experienced a slight prickling sensation in the tips.

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## American Medical Times.

SATURDAY, JULY 21, 1860.

## OUR SANITARY DEFENCES.

To DEFEND and relieve our fellow men from the preventable causes of disease, is manifestly the highest mission and best service of medical science and skill. And this is no trivial task, for ceaseless vigilance is the price of perfect and continued health. Indeed, life itself is a conflict so universal and perpetual, that we find but an axiomatic truth in that singular definition by the philosophic Bichat—"Life is the sum of the forces that resist death." This ceaseless conflict in defence of life and health seems to be the inevitable destiny of man; and in the civic community and the state, no less than in the individual, must it be vigilantly maintained.

All nations, from the remotest antiquity, have exalted medical art just in proportion to the success of its application to the defence and protection of the people from the preventable causes of disease; and in mythological history is recorded the exalted apotheosis of those early physicians who promoted great sanitary improvements. The ancient Fathers of Medicine were teachers of hygiene; and we know that while the populace of Athens and of Rome, in fear of pestilence, made votive offerings to *Puretos* and *Febria*, the disciples of Hippocrates sought out the true causes of prevailing diseases, and becoming the counsellors of statesmen and persons in authority, they secured for the people the proper measures of sanitary protection. Even now, as the tourist threads his way across the Pontine Marshes, and, in his approach to the Eternal City, treads the ancient Russ of the Appian Way—viewing afar the remains of immense aqueducts, or noting the extent of outline, and wonderful design of those vast subterranean galleries and cloacæ that made Rome the "*urbs pensilis*," how forcibly and definitely does the unwritten story of those ruins of ancient and effective Sanitary Works, declare to us, after nearly a hundred generations, that most vigilantly and vigorously the Romans guarded that physical health which made the Cæsars politically strong, and their capital once impregnable.

Sanitary defences and hygienic rules for the person, the domicile, the municipality, and the state, have always been

found necessary alike to the physical, social, and political prosperity of communities and nations. And if it be true that health and length of days are man's normal estate, it is equally true that disease, frailty, premature decay, and untimely death, are so liable to be his inheritance and lot in this world, that vigilant care, invention, and effort to preserve health, are the established conditions upon which that natural boon is to be perpetuated and enjoyed.

From the earliest ages, and in all communities, history has developed the fact that a high death rate, and frequently recurring endemic and epidemic diseases, mark the earlier period of the growth of cities, as well as the period of their decline; while the remedial agencies by which the public health, and the average duration and probability of life have been increased in any city or nation, conclusively demonstrate at once the necessity and the physical, economic and political importance of sanitary improvements and a code of Hygiene specially adapted to the protection of the public health in every city and state.

The practicability and inestimable value of such codes, and the works they sanction, are at present witnessed in the towns and cities of Great Britain, France, Germany, Austria, and Prussia,—where, notwithstanding the many unfavorable hygienic conditions and influences of a dense and constantly augmenting population, the average duration of human life is continually increasing. For example, in the city of London, during the greater part of the sixteenth century—the century preceeding the great plague—the average duration of life was only twenty years—fifty persons dying annually out of every one thousand of the inhabitants. At that period the streets of London were narrow, ill-paved, and extremely filthy; the sewers were imperfect and badly constructed, water was but scantily supplied, dwellings were over-crowded, and cleanliness was neither encouraged nor enforced. But now, in the middle decade of the nineteenth-century, with its population increased to millions, the average duration of human life in that crowded metropolis has been nearly doubled,—being thirty-seven years—the rate of mortality having fallen to twenty-five in one thousand of the population.

The means by which this astonishing and humane result has been accomplished are simply hygienic, and yet only by a very limited application of such means. Those hygienic measures—the Sanitary Defences of London—consist of—1. A Sanitary Code, sanctioned and enforced by authority of the State, through the agency of the General Board of Health; 2. A Chief Medical Officer of Health, distinguished for professional learning and executive ability; 3. Thirty-two subordinate and skilled Medical Officers, whose duty it is thoroughly to canvass and search out the foci and causes of disease in their respective parishes or districts; 4. Special improvements and public works under municipal direction, specially designed and adapted to promote the improvement of the public health.

Equally efficient are the sanitary systems of the larger continental cities. They have all learned something respecting the economic and political importance of public salubrity; and they have also learned to trust less in *cordons sanitaires*, and more in *SANITARY WORKS*.

New York and our larger American cities successfully vie with the great cities of Europe in all that relates to commercial enterprise, manufactures, popular intelli-

gence, and the practical applications of science and art; but where and what are our sanitary defences? With an abundance of skill and learning in medicine, with hospitals and medical charities unsurpassed by any other city, and with natural advantages equalled by none, this proud and favored metropolis of the western continent has the ignoble reputation of the highest death-rate of any city of equal size in the civilized world—all from preventible causes! This unenviable reputation and the guilt of out-heroding Herod in the destruction of an infant population, is simply the result of criminal neglect. NEW YORK has no Code of Hygiene and no Sanitary Defences worthy the name.

For the purposes of the appeal we would make to our medical brethren, we need not recount in detail the frightful statistics of mortality and disease in this city. It is our design to examine, and from time to time discuss in these columns, some of the more important questions relating to public hygiene and the sanitary systems—external and internal—of our American cities and large towns, strictly with reference to the duty and influence of the profession, and the elucidation of medical problems and scientific facts, in promotion of sanitary improvements not only in the city of New York, but throughout our country. The march of sanitary improvement has commenced in some of our American cities, and to the honor of the State of Massachusetts, it should here be stated that, at the recent session of her Legislature, that flourishing Commonwealth set its statutory seal upon the General Code of Health that was last year adopted and recommended by the National Sanitary Convention. Such evidence of progress is encouraging and unmistakable, and from the increased attention to hygiene as a department of medicine, as well as by the deep interest evinced in various practical branches of the subject at the recent meeting of the National Convention at Boston, it is sufficiently manifest that Preventive Medicine is popularly and justly regarded as the most exalted dispensation of the applied sciences.

The time has come when every physician should take an active part in efforts to promote sanitary improvements, awaken public interest, and wisely guide the popular sentiment respecting the subject. Our fellow-citizens throughout the State are beginning to be properly interested; and it cannot be doubted that they would readily co-operate with the medical profession in practical efforts to secure the enactment of a General Health Law for the State, with a Sanitary Code for our cities, like that recommended last year by the National Sanitary Convention, and this year adopted by the State of Massachusetts. Why should an enlightened and free people, blessed with abundant means and a healthful climate, pay needless tribute to the demon of Disease? Public health is not only a matter of national and municipal concern, but to every citizen and family it is a subject of far greater moment than the ordinary affairs of the city or State. The watchword of the people should be,—“Millions for defence” from disease,—not a cent nor a vote for “tribute” to the abettors of needless death.

With these thoughts we close this article, intending, however, to recur to this all-important subject on proper occasions in our editorial columns, and thus endeavor so to stimulate professional and public sentiment as to ensure the establishment of suitable Codes of Health in all our American cities.

## THE WEEK.

THE records of mortality in this city, for the last week, contain the following item: Deaths by violence, THIRTY-THREE. New York is rapidly acquiring an unenviable reputation for violent deaths. The details of murders and suicides are so constantly the burden of our morning news, that it requires something quite novel in the manner or circumstances of the deaths to attract especial attention. A chapter of domestic scandal which is frequently thereby revealed, or a profound mystery as to the murderer, gives a zest which the public relishes. And sometimes even a sense of horror is awakened, as when a sloop floats up the bay, all begrimed with blood, and all over which gory hands and struggling feet have traced in legible characters, *violence, murder, robbery*; or when a citizen, walking a on public thoroughfare, is deliberately shot, and the *posse comitatus* flying in pursuit of the assassin, another person is also shot down, and the murderer escapes. Although the majority of deaths by violence occur among the dissolute and lower classes, yet the past week or two has furnished marked exceptions to this rule. No one could have read the murders of Walton and Matthews, and the not less revolting murders of Mrs. Schumaker and her child, without feeling the insecurity of human life in this city, when it stands in the way of passion or avarice. The evil influences that are at work in our social state and of which these crimes are the natural fruit, are not difficult of detection, and we shall as the occasion presents make them the subject of special consideration.

The visit of the CHICAGO ZOUAVES to our Eastern cities may properly be regarded with interest by physicians and sanitarians, as being happily adapted to awaken greater attention to the subject of physical education. Here is a company of young gentlemen, who, by strict adherence to physiological laws in all their personal habits, no less than in their special manual exercises and military evolutions, have acquired such dexterity, muscular strength, agility, and astonishing powers of physical endurance, that the press, the populace, and the military of New York can scarcely find words to express the universal admiration and surprise which this young military corps has excited among us. How different this from the degrading engagements of acrobat showmen and the pugilists, both in results to the actors and the effects upon the community! The time and means expended by these young men have been amply rewarded in the increase of enduring physical energies in their own persons, while their wonderful agility and their perfection of *physique*, as manifested in all their manœuvres, fascinate all beholders, and strongly confirm the opinion, that “the *zouave-iter in modo is fortiter in re*,” no less for the individual man than in the active service of the military corps. Perfect ease of posture and complete command of every muscle are strikingly exhibited in every movement of these men—the well-trained muscles and healthy frame of each individual soldier happily illustrating the theory of the effectiveness of the Zouave corps in battle—viz. complete *unity of purpose* with perfect *individuality of action*. We recommend to young men both the gymnastic training and the peculiar physical habits of these citizen soldiers, especially their rigid abstinence from all that can intoxicate.



## Reviews.

DE L'HÉMATOCÈLE RÉTRO-UTÉRINE ET DES ÉPANCHEMENTS SANGUINS NON-ENKYSTÉS DE LA CAVITÉ PÉRITONÉALE DU PETIT BASSIN, CONSIDÉRÉS COMME ACCIDENTS DE LA MENSTRUATION. Par le Docteur AUGUSTE VOISIN, etc. etc. Avec une Planche. Paris: J. B. Baillière et Fils. 1860. 8vo. 368 pp.

RETRO-UTERINE HEMATOCELE AND NON-ENCYSTED EFFUSIONS OF BLOOD IN THE PERITONEAL CAVITY CONSIDERED AS ACCIDENTS OF MENSTRUATION. By Dr. VOISIN, with a lithographic plate.

THE author first presents a short abstract of the history of his subject, which he divides into two epochs, the former referring to the literature before 1850, the latter, after that date. It was at this period that the disease was for the first time called hematocele by Prof. Nelaton, it having been formerly neither recognised nor classified properly.

The author presents the views of different authors with regard to the nature and seat of the disease, and again points to the fact, as may already be seen from the title page, that he calls those sanguinous epaichements hematocele, which have been encysted.

Of the different names proposed, hematocele retro-uterine, hematocele péri-uterine, tumour sanguine du bassin, the first is adopted. With regard to the question of intra- or extra-peritoneal location of the deposit, Dr. Voisin recognises only the former variety. He considers hematocele retro-uterine an effusion of blood, which is encysted in the pelvic peritoneal cavity between the uterus and rectum, originating from the process of menstruation.

Hence all deposits of blood not occurring at the time of ovulation, not situated behind the uterus in the peritoneal cavity, and not encysted, are excluded from his consideration. The disease in question seems to be of infrequent occurrence, as scarcely fifty observations are known. We believe that this number will, however, increase considerably during the next few years, and will have the same history as Bright's and Addison's disease. When the knowledge of its pathology spreads among the profession, the diagnosis will be more readily made and the number of cases increase. After a minute description of the blood-vessels, which surround the Fallopian tubes, and the ovaries, the author proceeds to expose the different theories in regard to retro-uterine hematocele. Dr. Nelaton attributes this accident to what he calls *porte spontanée*, the blood which, during menstruation, is destined to pass from the ruptured Graafian follicle, through the Fallopian tube, into the uterus, escapes instead, into the peritoneal cavity in large quantities. Dr. Langier adopts this theory, adding the remark that, in order to produce an hematocele, there must exist an abnormal congestion of the ovary more intense than that due to simple menstrual afflux.

*Ovarian Apoplexie* has been considered as the cause of hematocele retro-uterine by Scanzoni, Puech, Nelaton, and formerly by Langier. Dr. Voisin is of opinion that the apoplectic character of the hemorrhage found in the cases described, has not been demonstrated. He considers it to be rather a hemorrhage by congestion "because apoplexie would imply a destruction of the tissue." *Hemorrhage of the Fallopian tubes*, as a cause of hematocele, has been admitted by Drs.

Fénerly, Scanzoni, Trousseau, Puech, and Oulmont, and this origin is admitted as an occasional cause of hematocele. *Reflux of the blood from the uterus into the peritoneal cavity by way of the tubes* has been considered by Drs. Bernutz, Ruysch, and Ilélie as a cause of hematocele. In the author's opinion all that can be said regarding this theory is, that the question is as yet not decided either in the affirmative or negative, and that more numerous observations than those extant are required to settle it.

Dr. Vigné's and Gallaud's opinion, who trace the origin of hematocele to a *dislodgment of the fecundated or non-fecundated ovum into the peritoneal cavity* seems not very probable—extra-uterine pregnancy, with rupture of the sac and hematocele, are affections of an very different nature. Drs. Richet and Devalz admit a *varicose condition of the ovarian veins and of the broad ligaments* as a cause of hematocele, which accident Dr. Voisin believes to precede sometimes the formation of a free sanguineous effusion, but not a real hematocele.

Among the *predisposing causes* may be mentioned a peculiar condition of the blood, such as is found in eruptive fevers; further a plethoric state, a menorrhagic tendency, constipation as it predisposes to varices of the pelvic veins. Among the *exciting causes* may be counted, in the first place, the catamenial flux. In seven out of ten cases where the accident occurred during menstruation, sexual intercourse was performed during or soon after that time, and in three others it could be traced to undue bodily exercise while menstruation was going on; in five others to mental emotions and fatigue.

*Pathogenesis.*—Retro-uterine hematocele may be produced by three different causes, viz:—by a congestion and hemorrhage of the ovarian vesicles during menstruation; by the reflux of blood from the uterus into the tubes and peritoneum; by a tubal hemorrhage. The non-encysted effusion of blood may be owing to either of the three above-named circumstances, and besides may be the consequence of a rupture of the sub-ovarian varicose veins. Opposed to Prof. Trousseau's theory, who holds that, during menstruation the "enucleation" of the ovulum was performed without any hemorrhage, Dr. Voisin proves, by the authority of the best French physiologists, that the ovarian vesicles may, even under ordinary circumstances, give rise to a slight hemorrhage at the time of the dislodgment of the ovum. Besides this physiological state, favorable to the production of a hemorrhage, there are many observations recorded to prove that the ovary is very often subject to pathological conditions apt to increase this hemorrhagic tendency. These alterations have been proven to consist in an excessive development of one or more of the Graafian vesicles, the consequence of which is an equable hypertrophy of the vascular apparatus, a more active circulation, and a predisposition to bleeding. If the proofs are abundant to show the existence in the ovary of conditions promoting hemorrhages, the number of post-mortem examinations (seven recorded) already known, do not leave the least doubt as to the this cause in the promotion of hematocele. An ovarian hemorrhage may be due to three different causes, viz: to a venous congestion of the ovary, an altered constitution of the blood (excess or decrease of fibrin), and to hémophilig. The venous congestion may again be caused by too frequent sexual excitement, constipation, and the immoderate use of the corset.



*Tubal Hemorrhage.*—The mucous membrane of the tube is the seat of a sanguineous exudation during menstruation, which discharge may, in some instances (obs. of Follin and Oulmont), increase to such a degree as to effect an hematocele. The *reflux of blood from the uterus into the peritoneum* is a very rare cause of retro-uterine hematocele, and, till now, it seems to have been produced only in connexion with a flexion of the womb.

The non-encysted effusions of blood into the peritoneal cavity of the pelvis, owe their origin to the same sources as the hematocele, and may also be the result of a rupture of sub-ovarian varices. Six observations are reported where the accident was produced by an ovarian hemorrhage; in four cases *tubal hemorrhage* was the cause, and in three instances *reflux of the blood* originally deposited in the uterus. The influences which give rise to the development of varices in the veins of the ovary and the broad ligament, are the absence of protecting sheaths to these vessels, their vertical direction, former pregnancies, and the use of the corset. These vessels are not furnished with valves. The stasis in the right utero-ovarian vein is more common than in the left one, on account of its direct issue into the vena cava. In four instances a rupture in one of the veins has been observed. The fact that sudden death ensues in all cases of hemorrhage from this latter cause, may be explained by the following circumstances:—The blood is furnished by a large vessel, and the vessel once ruptured, is very little disposed to contract, on account of its varicose condition. Menstrual congestion alone would hardly be sufficient for a rupture of the veins, and indeed in almost all the cases reported there was an accessory cause, such as fatigue and sexual excitement.

The cause of the discharge of blood into the peritoneum, in a case of ovarian hemorrhage, is an imperfect attachment of the pavillon of the tube to the ovary, either in consequence of a detachment owing to the large amount of blood from the ovary, or that a perfect apposition is prevented by false adhesions or tumors. The "enkystement" of the blood is favored by the tardiness of the bleeding and the pure state of the blood, while the non-enkystement is dependent upon a large amount of blood, suddenly discharged, and from a previous alteration of the blood. The blood once in the peritoneal sac, soon gravitates towards the lowest point, the cul-de-sac behind the uterus. It here excites an exudative inflammation, and adhesions are formed between all the pelvic organs. The cavity of the cyst may remain unilocular, but in most cases it is traversed by a great number of thin fibrinous bands, so that it may appear to be located in the subserous cellular tissue, thus being mistaken for an extra-peritoneal hematocele.

The symptoms of a free hemorrhage into the abdominal cavity are those of a violent peritonitis with anemia. Death ensued in all cases in less than twelve hours. The occurrence of symptoms in a case of retro-uterine hematocele is variable, sometimes slow, sometimes rapid; abdominal pains during previous menstrual periods were observed in the greater number of cases. In sixteen cases irregularity or amenorrhœa were noted down, in one a menorrhagic disposition. The pain occupies one or the other of the iliac fossæ, the pubic region, the lower part of the back, or even the inferior extremities. The pain has an expulsive character, or that of bearing down. In the course of the disease it disappears, to be renewed at some of the next menstrual

periods, even after the disappearance of the hematocele. The increased size of the abdomen is partly due to tympanitis intestinalis, partly to the pressure of a quantity of blood in the pelvis. The tumor, which may be felt in the abdomen, attains its highest development in the first few days, but in a few instances it increases in size for a month to come. The diameters of the tumor vary from those of an orange up to those of a full-grown child's head. The consistence of the tumor varies according to circumstances, at first it is soft, and becomes more solid and often nodule (rugged) afterwards. The tumor may be easily perceived by the vaginal touch behind the uterus; in some cases fluctuation could be perceived, while the womb is displaced upwards or in a lateral direction. In a very limited number of cases a violet coloration of the posterior roof of the vagina could be perceived by the speculum. The vaginal neck is very generally unmovable and pushed towards the symphysis pubis and sometimes displaced towards the right or left side. The womb is only very seldom thrown upwards. In some instances a dysentery followed the disease, very likely in connexion with the rapid resorption of the liquid mass.

The *course* of retro-uterine hematocele is generally very rapid; its absorption is effected successively during the following menstrual periods; its duration takes four months as a general rule; perfect recovery is the rule in cases where no surgical treatment is resorted to and the tumor is absorbed, or it opens into the rectum or vagina. It very rarely opens into the peritoneal cavity, nor does its contents frequently become purulent.

The *diagnosis* of retro-uterine hematocele is based upon the generally large amount of blood discharged at the time of the menses, the connexion of the outset of the affection with the time of menstruation, the rapid course of the accidents, the resemblance of the symptoms to those of a peritonitis, the quick and enormous development of the tumor, the almost instantaneous appearance of anemia, the projection in front of the uterine neck, the presence of a retro-uterine tumor, and the character of the pains, which are compared by the patients to those experienced at the time of labor. In some cases it is possible to determine the primary cause of the affection, the source of the hemorrhage. The co-existence of varices in the lower extremities or the vagina, of hemorrhoids, and of an abundant menstrual flux make it probable that the bleeding comes from the rupture of a varix of the utero-ovarian plexus.

The pre-existence of lateral hypogastric pains with increased intensity every other month, alternating hemorrhages, previous pregnancies, rectal varices, and varices in the leg corresponding with the side of the hypogastrium, which is painful, are illustrative of an ovarian hemorrhage. A flexion of the uterus or an obstruction in the uterine canal indicate that the blood was furnished by the uterus itself. The diagnosis of a tubal hemorrhage is impossible. Diseases which might be mistaken for hematocele are: peritoneal phlegmon, retro-uterine abscess, oophoritis, encephaloid tumors, ovarian cysts, tubo-ovarian cysts, extra-uterine pregnancy, fibrous tumors of the uterus, retroversion and retro-flexion of the uterus, varices of the broad ligament, thrombus of the broad ligament, retention of feces, and plastic indurations behind the uterus. The diagnostic features of all these accidents are considered briefly. Hitherto there has not been a single fact published that

proved the extra-peritoneal seat of hematocele, and it has been demonstrated by numerous autopsies, that the sanguineous tumor is always situated intra-peritoneal.

The *prognosis* of hematocele is generally favorable, except in those cases where pus is formed, or where the decomposed contents of the sac are ruptured into the peritoneum. In one case the patient became pregnant afterwards and was delivered of a healthy child.

*Treatment.*—The tendency to a new hemorrhagic attack must be treated by absolute rest in a recumbent position, local applications of cold, astringent remedies, acids, and revulsives. The tumor must be treated by cataplasms, flying blisters and derivatives; the anemia, by iron, tonics, and generous food. The surgical treatment resulted in death in one-fourth of the cases. It ought to be restricted to those instances where a strong tendency to decomposition of the encysted blood and perforation into the peritoneum is to be dreaded. The history of thirty-five cases is added. In conclusion, we give it as our opinion that Dr. Voisin's treatise will become the standard work on hematocele. It contains all that is known up to the present day on the disease in question; it reveals an admirable knowledge of literature, and is particularly valuable on account of the large number of observations contained in the appendix. We can hardly recommend it sufficiently strong enough to our readers. The only remark we venture to make regards the division proposed in the description of the disease. The free discharge of blood into the abdominal cavity is treated of apart from hematocele, properly so called, ostensibly on the plea that one cause of the accident, viz. rupture of a varix in the utero-ovarian plexus, would be always followed by violent hemorrhage, and consequently death, thus excluding the possibility of "encystment." In most instances this is the case, but it cannot be demonstrated that some of the cases which recovered were not hematocele, and were not originally due to a rupture of a varicose vein, inasmuch as a precise diagnosis of the several causes of hematocele is, in the majority of cases, out of the question during life.

E. N.

**INSECTICIDES.**—I have directed chamomile powder—that is to say, the flowers carefully dried in an oven, then powdered, to be dusted on the parts, in four cases, two of them children, infested by lice. I directed brown soap and warm water, liberally employed, twice daily, then the chamomile powder, previously confined in a muslin bag, to be well dusted in. The result in every case, and within a very brief period, was the destruction of these hideous parasites. —*Dr. McCormack, Dublin Med. Press.*

**HEALTH OF LONDON IN THE 17TH AND 19TH CENTURIES.**—To show the marked difference between the death-rate in the seventeenth and the nineteenth centuries, the Registrar-General has given us some very interesting details; and it appears that the comparison may be relied on as tolerably correct. In the 20 years, 1660–79, the death-rate was 7,000 in 100,000; in 1859, it was 2,229. Small-pox took off 357 in the first period, and 42 in the second; fever, 749 and 59 in the two periods. In those days, 86 died in childhood, now 17 die in the 100,000. Now 8 die of dysentery, then 763 died. Syphilis was twice as fatal then. Scurvy also took off its 142 instead of 2 as now. Respiratory diseases were very fatal; 1,079 then, against 611 now. Convulsions and teething carried off 1,175; and now (sadly still too many) carry off 136. Besides this, in those days there were visitations of the plague—in 1665, for instance, nearly one-third of the population perished by plague.—*Medical Times and Gazette.*

## Progress of Medical Science.

### SURGERY AND SURGICAL PATHOLOGY.

*Practical Observations on the Nature and Treatment of Prostatorrhœa.* By PROF. GROSS, Phila. (*North Am. Med. Chir. Rev.* July, 1860.)—Prostatorrhœa is defined to be a discharge from the prostate gland, generally of a thin mucous character, dependent upon irritation, if not actual inflammation, of the component tissues of that organ. It has generally been confounded with other lesions, as gleet, or chronic urethritis, seminal losses, and cystorrhœa, or chronic inflammation of the mucous membrane of the bladder. It does not often occur among children or old people, but is most common during the activity of the sexual organs, and is most frequently met with in those whose sexual propensities are the strongest. The exciting causes are not always evident, but the disease has generally been traceable, either directly or indirectly, to venereal excesses, chronic inflammation of the neck of the bladder, stricture of the urethra, or some affection of this canal; it may have its origin in diseases of the rectum, and the use of internal remedies, as cantharides, turpentine, may excite a temporary prostatorrhœa; a common cause in young men is masturbation. The *symptoms* are a discharge of mucus, generally, perfectly clear,ropy, varying from a drachm upward in twenty-four hours; in efforts at defecation the flow is greatest. It is attended, also, with a pleasurable, tickling sensation sometimes. Prostatorrhœa may be distinguished from urethritis by the gradual supervention of symptoms, the transparency of the discharge, the absence of symptoms of inflammation of the urethra, &c.; from spermatorrhœa, by a microscopical examination of the discharge; from cystorrhœa by the absence of changes in the urine, or difficulty in micturition. The *pathology* of this affection consists in a disorder of the follicular apparatus, leading to an inordinate secretion of its peculiar fluid. This may be due to inflammation, but in some instances the organ appears to be entirely healthy, in which case it is supposed to be due to a heightened functional activity. The *prognosis* is generally favorable, as this affection is not a disease but a symptom of disease, usually slight, and easily removed; it is often, however, very obstinate, and when the mind deeply sympathizes with the local affection is very difficult of management. The *treatment* should be directed to the removal of the cause, and to this end there should be a thorough exploration of the genito-urinary apparatus, the anus and the rectum, and a careful inquiry as to the habits of the patient. If he is weak, gentle exercise, nutritious diet, wine and tonics are indicated. The tincture of the chloride of iron in union with tincture of nux vomica is especially recommended; if he is plethoric, the antimonial and saline mixture is useful; the most useful topical applications are cooling and anodyne injections, as Goulard's Extract with wine of opium in the proportion of one or two drachms each in ten ounces of water, three times daily; in obstinate cases, cauterization once a week may be necessary; the cold hip bath is also important, and if the symptoms do not yield, leeches should be applied around the anus and to the perineum.

*Excision of the Head of the Os Brachii following a Gunshot Wound.* By PROF. PAUL F. EVE, Nashville. (*Nashville Jour. of Med. and Surg.*, July, 1860.)—Prof. Eve remarks that, according to Mr. Birkett of London, in no case of excision of the head of this bone has the patient regained the power of raising the arm above a right angle with the trunk or above the level of the acromion. The case which he details was followed by a better result. The patient was sixteen years of age, and accidentally received a gunshot wound of the shoulder, the charge traversing the upper extremity of the os brachii and opening the shoulder-joint. There was but little hemorrhage. The operation consisted in making a flap of the deltoid, and thus exposing the shattered

head of the os brachii which was removed. The wound was cleansed and dressed, and the patient convalesced favorably. At the end of six months he had good use of the limb and was able to raise it to a level with the clavicle.

*Statistics of Ligation of the Primitive Iliac Artery.* By DR. STEPHEN SMITH, of New York. (*Am. Jour. Med. Scien.* July, 1860).—This paper comprises the reports in abstract of 32 recorded cases of this operation, arranged according to the diseases or accidents which led to the operation, as follows:—1. For the arrest of hemorrhage, 11 cases. 2. For the cure of aneurisms, 16 cases. 3. For the cure of pulsating tumors, which proved to be malignant, 4 cases. 4. For the prevention of hemorrhage in the removal of a tumor, 1 case. Of these 32 cases, 25 died; being a mortality of 78½ per cent. In 24 cases aneurisms directly or indirectly led to the operation, and involved the following arteries; right external iliac, 11; left external iliac, 7; femoral, 1; gluteal, 2; one was varicose; not given, 2. In 17 cases the right primitive iliac artery, and in 13 cases the left was tied; of the former 3, and of the latter 2, recovered. In 9 cases the peritoneum was wounded, of which one recovered. It appears from this paper that the operation of ligating the common iliac is much more fatal than authors have represented.

*Passage of a Rake Handle through the Scrotum and Abdominal Parietes—Recovery.* By DR. BURNHAM, of Epping, N. H. (*Bost. Med. and Surg. Jour.*, July 12, 1860).—A laborer sliding down the side of a hay-mow encountered the upright handle of a rake, which entered at the lower or inferior portion of the scrotum, a little to the left of the mesial line, passing up over the pubes, then running somewhat diagonally across the abdomen, made its exit in the right hypochondriac region, between the tenth and eleventh ribs. The left testicle was completely turned out of its place and almost denuded of its covering. The rake handle was removed, no hemorrhage followed, and with the exception of an abscess, which formed in the track of the wound, the patient recovered without any bad symptoms.

*Application of the Button Suture in Treatment of Varix.* By DR. BOZEMAN, of New Orleans. (*New Orleans Med. and Surg. Jour.*, July, 1860).—The peculiarity of this method consists in using silver wire and the button suture instead of bougies. Dr. B. places his patient in the upright position in order to have the veins enlarge, and then passes the needle around it; the ends are drawn through the button which is slid down upon the vein and secured by compressed shot. Two cases are reported in which this method proved perfectly successful. Dr. B. has applied this method also to varicocele with success.

*Compound Fracture of the Skull, with Depression of Bone and no Symptoms of Compression.* By DR. RICHARDSON, of New Orleans. (*North Am. Med.-Chir. Rev.*, July, 1860).—Dr. Richardson reports the case of a man who entered Charity Hospital with a compound fracture and angular depression of the frontal bone but without symptoms of compression. Two small fragments of bone were removed through the laceration of the scalp, cold water dressings applied, and the patient rapidly recovered. Prof. R. states that this is his method of treating similar injuries, in opposition to British and American authorities. While the latter advise non-intervention when the fracture is not compound, Prof. R. contends that there is in such cases greater liability to inflammation than in a compound fracture, and therefore the argument in favor of not operating in simple fractures with depression applies with still greater force to cases of compound fracture with depression. He adds that it is a fact established by statistics, as well as by common observation, "that the number of persons who recover after compound fracture with depression, in whom the trephine is not employed, is far greater than of those who have been subjected to the operation." He refers to the following statistics of Lawrie and King, in the *Edin. Monthly Jour.* 1844, of 77 cases of compound fracture, 26 were not trephined and 18 were cured; 51 were trephined and 11 were cured.

*Subnitrate of Bismuth in the treatment of Burns and Scalds.* By DR. RICHARDSON, of New Orleans. (*North Am. Med.-Chir. Rev.*, July, 1860).—Dr. Richardson was induced to use bismuth in the treatment of burns from its well known effect in calming irritation and even actual inflammation of mucous membranes. The following is the method of employing it:—rub the bismuth in a mortar with a sufficient amount of glycerine to form a paste or thick paint, which should be applied to the affected surface by means of a camel's hair pencil, or a mop made of soft linen; the parts should be first thoroughly dried and each blister opened with a needle; after a thick coat has been applied the parts should be protected from the bed clothes by a layer of clean carded cotton. In burns of the first degree one application will often suffice, but in those of the second it may be necessary to repeat it, in part at least, from day to day, in consequence of its disturbance and the wetting of the cotton by the discharges. This method of treating burns has proved superior to every other in the Charity Hospital.

## Reports of Societies.

### AMERICAN MEDICAL ASSOCIATION.

#### SECTION ON SURGERY.

(Continued from page 35.)

Dr. WILLARD PARKER, of N. Y., remarked, in relation to the treatment of the disease in question, that inasmuch as it occurred in scrofulous children, the constitution was the main thing to be looked after; any local appliances being a secondary matter. The constitutional treatment required was sustaining in its character. If any apparatus could be suggested, by means of which the patient might avail himself of exercise, and at the same time keep the tender surfaces apart a great point would be gained. It seemed to him that Dr. Sayre's apparatus was the result of an old suggestion, and that due credit, as the prime mover in the affair, should be given to Dr. March. He thought that the principle of treatment, as laid down by that gentleman, was a correct one—the prevention of pressure, and the consequent destruction, not only of the synovial membrane, but the cartilage and bony structure.

In reference to the time for opening joints, he did not think it was a question that had been satisfactorily answered. He had some experience in puncturing knee-joints, though he never had occasion to perform such an operation upon the hip. In this connexion he thought it necessary only to refer to a single case of the former class, which might be considered as a type of the whole. It was in a young boy, ten years of age, whom he saw in consultation with a surgeon of New York City. The child at that time had been suffering intense pain for some days in consequence of pressure produced by an accumulation of fluid in the cavity of the joint, which had been the seat of acute synovitis. The pain was so intense, that the administration of opium and chloroform was found to be entirely useless, as far as any good effects were concerned. The question naturally enough came up—What was to be done? It was finally decided that an opening should be made. This was accordingly done by a thumb-lancet, when so great was the tension of the parts, that the fluid was forced to the extent of fully two feet from the aperture. The fluid, upon examination, was found to be of the nature and consistency of gelatine. The system soon afterwards became tranquil, and sleep followed the administration of an ordinary anodyne. In the course of time, a complete recovery was the result. He could not see the difference between joints which were already the seat of suppuration, where the synovial membrane and cartilage were destroyed; and ab-



cesses in any other part of the body. The indications for evacuation of the contents of the joint were equally strong in both instances.

Dr. ATLEE, of Pennsylvania, thought it was his duty to give his experience in relation to opening of joints, by citing the following case: The patient was a German servant of his, 18 or 19 years of age, with a highly scrofulous constitution. He was observed limping about the house, apparently in great pain; and on being questioned, he told the doctor that for some days he had suffered from severe pain in his knee-joint. Upon examination, the part was found very much distended, and his suffering was so intense, that it was evident that immediate relief should be given, or else suppuration would be the result. A small trocar was introduced, and about eight ounces of highly albuminous fluid was drawn off. The relief was immediate, and instead of having him laid up for three or four months, in three weeks after he was perfectly recovered. He stated, in conclusion, that previous to being compelled to perform the operation, he had always a prejudice against puncturing joints; but the result of this case tended to alter his views in relation to that point.

Dr. McDOWELL, of St. Louis, stated that he would have given all that he had ever made in his profession, and all he expected to make, if he had known of this instrument when his son had morbus coxarius. He should have punctured the joint early, then have applied the instrument, and would have been rewarded by saving his boy. In reference to opening into the knee-joint, he stated that he had performed the operation in four instances. In one case, ankylosis was the result; and in three others no serious damage took place. In conclusion, he expressed a determination to follow out the principles of treatment as set forth in the discussion.

Dr. F. H. HAMILTON remarked, in relation to the treatment of hip-disease, that he had been early instructed with reference to the necessity of confinement, but that experience had since taught him the unsoundness of such a principle. He had come to the conclusion, that such confinement was in direct antagonism to another and equally important indication, namely, the restoration of the general health. He maintained that, in a very considerable number of cases belonging to the incipient stage, the progress of the disease might be arrested by establishing or confirming the general health. If the child was past six years of age, this was not a very difficult thing to do. His plan was simply to instruct the parents to obtain crutches that were handsomely made of Malacca wood, and silver mounted, so that the child would not be ashamed of them, nor throw them aside when out among his playmates. By the adoption of these means simply, the patient would be tempted to take the requisite amount of exercise. To cases under the age referred to, he thought that Sayre's instrument was very well adapted. In reference to operations upon joints, he was convinced that there was not so much to be feared in opening them as in making that opening insufficient. He had resorted to the practice not only with impunity, but was satisfied with the result in every case.

Dr. JAMES R. WOOD, of New York, made in substance the following remarks:—The subject of opening joints has interested me for many years, and the opportunities offered for investigating the subject have been ample. The indiscriminate opening of joints is a very serious matter, but there are instances, where the experienced surgeon, by resorting to this practice, will do great good to his patients and credit to his calling. So great was the horror in reference to injury of the joints in days gone by, that even amputation and ligature of the femoral artery in puncture of the knee-joint has been resorted to by our best surgeons, and that within the last fifteen or twenty years. It was because of the resulting constitutional irritation, that this extreme practice was resorted to. I may be permitted here to offer a few thoughts on the different variety of cases in which the joint may be opened. The first is in those cases of traumatic trouble of the joint, where it is opened by punc-

ture as with a penknife, or as is not unfrequently the case, where this has been done, by a drawing-knife, in the hands of a cooper. This latter accident I have met with several times. These are the cases that were so much dreaded by the older surgeons. Here you have acute inflammation speedily terminating in acute abscess of the joint, and the sooner you allow the matter to escape by a free opening the better it will be for the patient; for by so doing, you escape the constitutional irritation and its consequences, also, the toxæmic effect from the absorption of matter. Again, as in the case related by Dr. Atlee, where you have the joint filling rapidly with serum, the result of a different grade of inflammation of the synovial membrane, producing excessive distension, excruciating pain, and consequent constitutional symptoms, because of the want of the elasticity of the tissues encroached upon, you are to make a small puncture as you would in the case of accumulation of serum or pus in the cavity of the thorax; close the wound at once and the relief is immediate. But let me be understood, that I would not resort to these practices in the cases instanced, unless the usual antiphlogistic treatment had been resorted to. I am convinced that it is good surgery, after they have failed, to open the joint as I have stated. Again, we have another form, and one which is very common, in our large cities; it is the result of a constitutional trouble occurring in badly fed patients, living in pent-up apartments, where the light of heaven and fresh air are seldom admitted; who are sustained by bad food and begotten by strumous or syphilitic parents. In this class of patients we have the disease called *fungus articuli*, by Sir Benj. Brodie, the old-fashioned *white swelling* of our fathers, no matter whether it occur in the hip, shoulder, elbow, knee, or the spine it is one and the same disease; and although the surgeon may do much, the medical treatment should never be forgotten, for without it all surgical appliances will be of but little avail. Give your patient good air, sea air if you can, plenty of light, out-door exercise as much as practicable, iron, wine, or ale, cream, roast and broiled meats, with blood-gravy, and so forth. In these cases, as a general rule, you have the integrity of the joint destroyed before you are consulted; a very different state of things from that existing in the cases already referred to. The synovial membrane, the cartilage of incrustation, and frequently the bone has succumbed to the peculiar grade of inflammation common to this disease. There is but little pain perhaps, but little heat, in fact the swelling about the joint and incapacity of use are the most prominent symptoms presenting themselves; if you exclude the constitutional trouble of the patient which it is not worth while to refer to here. As in the first form referred to, you have an abscess, but a very different one; in the first you have an acute, a hot abscess, but here you have a chronic or cold abscess. It is in all respects like the psoas abscess which occurs in the groin, or the lumbar in the loins. It is in these cases that I have occasionally opened the joints; but I am sorry to say, that my experience is such as to cause me to do it always with reluctance, and let me say here, Gentlemen, that it is my judgment that the good surgeon will always approach a joint with great deference and hesitancy. For even in this class of cases the majority of the patients whom I have operated upon, and those of my neighbors that have fallen under my observation, have either lost their limbs or their lives. Resection, although appearing much more formidable than the simple puncture of the joint, statistics warrant me in saying, is a very much more safe operation, and the results are very much more favorable.

Dr. TOWNSEND asked Dr. Sayre whether he would open the abscesses that occur upon the thigh in this disease?

Dr. SAYRE stated, that by the early use of his apparatus, and by following out the plan of treatment set forth, this complication would not take place. If, however, he should meet with a case where such an abscess existed, he did not see any reason why it should not be treated by a free incision as in any other instances.



On motion of Dr. Atlee, Dr. Sayre's paper was recommended by the section to the Association for publication in its Transactions. The meeting then adjourned *sine die*.

### NEW YORK PATHOLOGICAL SOCIETY.

STATED MEETING, MAY 23D, 1860.

E. KRACKOWITZER, M.D., President.

#### LARGE FIBROUS TUMOR OF UTERUS.

Dr. SANDS exhibited a specimen of very large fibrous tumor of the uterus removed from the body of an aged woman, who died from some cause unconnected with the development of the abnormal growth. After the removal of the mass it was with some trouble that the os externum was found, when it was seen to present very much its natural appearance. The canal of the cervix was somewhat increased in length, measuring about two and three-quarter inches. The cavity of the womb was also found to be much increased, having lost much of its original shape in consequence of the presence of several small tumors in the vicinity. The specimen on close examination was found to consist of a collection of tumors, each of them, however, connected together by pretty well marked fibrous tissue.

Dr. S. stated that he examined the specimens under the microscope with a great deal of care, in order to detect the unstripped muscular fibre which is said to exist in that variety of tumors. He however failed. The whole mass, after removal, weighed twenty pounds and ten ounces. In one or two places a calcareous deposit was found replacing what was formerly a fibrous mass.

Dr. KRACKOWITZER remarked that he had often examined such tumors in regard to the existence of the organic muscular fibre, but had never succeeded. He doubted not, however, that they did exist, and the failure in the detection of them, he was disposed to think, depended upon the previous preparation of the specimen. He remarked that Molleschott recommended the section to be placed for two months in dilute acetic acid (in the proportion of one volume of the acid to fifty-nine of water) when the fibres would be rendered visible under the microscope.

Dr. SANDS stated that he had seen it recommended by some one, to prepare the specimen in the first place by soaking it in dilute alcohol, and afterwards in dilute nitric acid, in the proportions as named by the President. He intended to follow out that plan and see what the result would be. In conclusion, he asked the experience of the members in reference to the earliest period of life that these fibrous uterine tumors were known to occur. He had a case under treatment of a young female, scarcely twenty, in whom he had very good reason to suspect the existence of such a state of things.

Dr. KRACKOWITZER believed that fibrous tumors in young people were of very rare occurrence; more generally showing themselves between the ages of thirty and forty years. These tumors gave rise to very little trouble, except when the female was impregnated, when they often were a serious matter. He stated that Spaeth, in one of the Vienna medical journals, published a case where a large tumor of that sort was attached by a pedicle to the fundus of the uterus, and at the time of labor occupied nearly the whole pelvic cavity, crowding the organ upwards, there being scarcely room enough left to introduce two fingers into the vagina. The mass, however, was pushed up into the abdominal cavity, the womb restored to its normal position, and the labor completed without any further trouble. The patient subsequently dying of puerperal fever, it was found that the tumor was about as large as a small head. Dr. K. referred to another case, published some time ago in which such a tumor was only recognised at the commencement of labor to reside in the anterior lip of the cervix, and whence it was enucleated in time to allow the parturient act to be completed in the usual way.

The Society then adjourned.

## Medical News.

### ARMY MEDICAL INTELLIGENCE.

By General Order No. 17, the following Assistant Surgeons to be Surgeons at the dates given.

Levi H. Holden, April 23, 1860, vice Wheaton, deceased.

Richard F. Simpson, June 23, 1860, to fill an original vacancy.

Richard H. Coolidge, June 23, 1860, to fill an original vacancy.

Chas. C. Keeney, June 23, 1860, to fill an original vacancy.

Robert Murray, June 23, 1860, to fill an original vacancy.

### APPOINTMENTS.

Assistant-Surgeon Albert J. Myer to be Signal Officer with the rank of Major, June 27th, 1860, to fill an original vacancy. (Dr. Myer's commission as Assistant Surgeon is vacated.)

The following gentlemen are appointed Assistant Surgeons:—Joseph H. Bill of Pennsylvania, vice Eaton, deceased, to date from April 13th, 1860.

James H. Berrien, of Georgia, vice Holden, promoted, to date from June 1st, 1860.

Dewitt C. Peters, of New York, June 23d, 1860, to fill an original vacancy.

Charles H. Alden, of Pennsylvania, to be Assistant Surgeon, June 23, 1860, to fill an original vacancy.

Warren Webster, of Massachusetts, to be Assistant Surgeon, June 23, 1860, to fill an original vacancy.

John Vansant, of the District of Columbia, to be Assistant Surgeon, June 23, 1860, to fill an original vacancy.

Charles C. Byrne of Maryland, to be Assistant Surgeon, vice Simpson, promoted, to date from June 23, 1860.

Archibald M. Fauntleroy, of Virginia, to be Assistant Surgeon, vice Coolidge promoted, to date from June 23, 1860.

### PERSONAL ORDERS AND MOVEMENTS.

Assistant Surgeon Warren Webster has been ordered to repair to Fort Larned, and report for duty at that station.

Assistant Surgeon C. C. Byrne has been ordered to repair to Camp Verde, Texas, and relieve Assistant Surgeon Foard.

Assistant Surgeon R. Bartholow has been ordered to report at Fort Columbus, N. Y., on the 16th of July, for duty with the recruits under orders for New Mexico.

Assistant Surgeon J. Vansant has been ordered to repair to the headquarters of the Department of Oregon, and to report for duty to the commander thereof.

Assistant Surgeon John Campbell has been ordered to Plattsburg Barracks, N. Y., on the expiration of his present leave of absence.

Assistant Surgeon A. J. Foard has been ordered to repair—when relieved from his present duties at Camp Verde—to Baton Rouge, La., and report thence by letter to the Surgeon General.

Assistant Surgeon Glover Perin, now *en route* to Ringgold Barracks from New Mexico, has been ordered to repair to Newport Barracks, Ky., and report thence by letter to the Surgeon General.

Assistant Surgeon E. W. Johns has been ordered to repair—when relieved from his present duties at Fort Larned—to the city of New York, and report thence by letter to the Surgeon General for examination for promotion.

Surgeon W. J. Sloan has been assigned to duty at Baton Rouge Barracks, and will be relieved from further service in the department of New Mexico, on the arrival of Assist. Surgeon R. Bartholow in that department. On his arrival at St. Louis, Mo., Surgeon Sloan has been directed to report by letter to the Surgeon General for special instructions.

## MEDICAL DEPARTMENT OF THE ARMY.

[Special Orders, No. 134.]

## WAR DEPARTMENT,

Adjutant-General's Office, Washington, July 5, 1860.

A Board of Medical Officers will assemble at Baltimore, Maryland, on the twentieth day of September next, or as soon thereafter as practicable, for the examination of Assistant Surgeons for promotion, and of such candidates for appointment to the Medical Staff of the Army as may be invited to present themselves to the Board.

Detail for the Board: Surgeon C. A. Finley, Surgeon R. S. Satterlee, Surgeon C. S. Tripler.

By order of the Secretary of War, S. WILLIAMS,  
Assistant Adjutant-General.

Applicants must be between twenty-one and twenty-five years of age.

Applications must be addressed to the Secretary of War; must state the residence of the applicant and the date and place of his birth. They must also be accompanied (references will receive no attention) by respectable testimonials of his possessing the moral and physical qualifications requisite for filling creditably the responsible station, and for performing ably the arduous and active duties of an officer of the Medical Staff.

There are, at this time, three vacancies in the grade of Assistant Surgeon.

**BROOKLYN CITY HOSPITAL.**—By the death of Dr. Isaacs a vacancy has occurred in the Medical Board of this Institution, which will be filled by the Trustees in October.

**UNION OF MEDICAL JOURNALS.**—The *Cincinnati Lancet and Observer* and the *Cleveland Medical Gazette* have united their editorial interests, and hereafter these journals will be issued simultaneously at Cleveland and Cincinnati. Each retains its own name, but essentially they will be the same in size and contents.

**AMERICAN HOMŒOPATHISTS AND THE BRITISH MEDICAL COUNCIL.**—At the recent session of the General Council of Medical Education and Registration, five graduates of Homœopathic Colleges of this country, viz. two from a Philadelphia and three from a Cleveland College, applied to be registered under a clause of the Registration Act, which admits graduates of Foreign Universities. The subject was referred to the Attorney General for an opinion as to the duties of the Council.

**THE OHIO STATE MEDICAL CONVENTION** recently met at Ohio White Sulphur Springs, and remained in session four days. Reports were made—on Surgery, by Dr. BAKER; on Obstetrics, by Dr. WRIGHT; on Obituaries, by Dr. Landon; on Cannabis Indica, by Dr. McMEENS; on Medical Literature, by Dr. STEVENS; on Diseases of the Eye, by Dr. METZ; on Typhoid Fever, by Dr. POMERENE; on the Effects of Chloroform upon the Intellectual Processes, by Dr. WRIGHT. The following persons were elected officers for the ensuing year:—President, Dr. H. S. CONKLIN; Vice-Presidents, Drs. McMEENS, BONNER, KINCAID, HUNT; Secretaries, Drs. DAWSON, GUNDY; Treasurer, Dr. JOHN B. THOMPSON; Librarian, Dr. ROBERT THOMPSON; on Admissions, Drs. MULLEN, HURTHAL, POMERENE, WALIER, MILLER.

**COMMENCEMENT OF CASTLETON MEDICAL COLLEGE.**—The exercises of the fifty-ninth commencement of the Castleton Medical College took place Tuesday evening the 12th, before one of the largest assemblies ever convened on a like occasion in Castleton, C. Spencer, President, in the chair. Diplomas were awarded to the following successful candidates for the title of M.D.:—S. Belknap, Vermont; M. Billington, New York; C. W. Bowen, Vermont; J. B. Chapman, Virginia; J. S. Crawley, New York; H. M. Hall, Illinois; A. J. Hart, Maine; G. H. Parkhurst, New York; J. C. Pomroy, Vermont; M. H. Searle, New York; W. H. Traver, Connecticut; E. A. Tupper, Nova Scotia; S. Weld and W. Scott, Canada West. Valedictory address by P. Pineo, M.D. The speaker was listened to with lively inter-

est, and the address was pronounced by all to be an instructive and valuable paper.

## WEEKLY REPORT OF DEATHS IN THE CITY AND COUNTY OF NEW YORK.

From the 7th day of July to the 14th day of July, 1860.

Men, 77; women, 85; boys, 149; girls, 131. Total, 442. Adults, 162; youths, 7; children, 273. Males, 226; females, 216. Colored persons, 5. Increase over previous week, 11; corresponding week of 1858, 553; decrease, 111. Corresponding week of 1859, 597; decrease, 156. Of these, 227 were reported by the general names of acute diseases; 145 chronic; and 21 resulted from violent causes. 218 infants died under two years of age. Among the causes of death this week: From apoplexy, 10; congestion of brain, 9; cholera, 2; cholera infantum, 52; cholera morbus, 5; infantile convulsions, 50; croup, 4; diphtherite, 3; diarrhoea, 17; dysentery, 6; scarlet fever, 19; inflammation of bowels, 12, of brain, 11, of lungs, 15; measles, 2; small-pox, 5; consumption, 53; dropsy of the brain, 17; marasmus, 24. The following is an attempt at a classification, viz.: Brain and nervous system, 105; Respiratory, 93; and Digestive, 143; Eruptive fevers, 26. Public Institutions, 61, viz.: Alms-House, 9; Bellevue, 19; City Hospital, 7; Island Hospital, B. I., 3; Lunatic Asylum, 4; St. Vincent's Hospital, 4; Ward's Island, 11.

## WEATHER FOR THE WEEK.

JULY.	Barometer.		Out-door Temperature.			Difference of dry and wet bulb. Therm.		General direction of Wind.	Mean amount of cloud.	Rain.
	Mean height.	Daily range.	Mean.	Min.	Max.	Mean.	Max.			
8th.	29.83	.11	70	60	79	7	11	NE. to SE.	6	
9th.	29.73	.10	78	66	89	8	18	SE. to SW.	6	.04
10th.	29.86	.10	79	69	88	11	17	SW. to SE.	8	
11th.	29.93	.13	78	66	78	12	17	NW.	2	
12th.	30.00	.08	72	64	80	13	18	"	25	
13th.	29.98	.05	68	60	77	10	12	NE.	2	.1
14th.	29.96	.04	72	60	82	10	15	NE. to SE.	1	

**REMARKS.**—8th. Fine day, with light winds. 9th. Shower at 6 A.M., morning damp. 10th. Fine day, wind fresh, A.M. 11th. Sunrise obscured, morning overcast, afternoon variable, wind light. 12th. Wind fresh A.M., day clear. 13th. Morning clear, shower at 3 P.M., evening clear. 14th. Sky hazy in the morning, weather fine all day.

## DEATHS.

**WEST.**—At Savannah, Ga., CHARLES W. WEST, M.D., Prof. of Chemistry in the Savannah Medical College.

**BRODBECK.**—On June 22d, at Dayton, O., CONRAD BRODBECK, M.D., aged 50.

**WENDELL.**—On July 11, at Brooklyn, MATHEW WENDALL, M.D., late Health Officer of that city.

## MEDICAL DIARY OF THE WEEK.

Monday, July 23.	{ CITY HOSPITAL, Surgery, Dr. Watson, half-past 1 P.M. BELLEVUE, Obstetrics, Dr. Elliot, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M.
Tuesday, July 24.	{ BELLEVUE, Medicine, Dr. Thomas, half-past 1 P.M. CITY HOSPITAL, Surgery, Dr. Parker, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M. OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M.
Wednesday, July 25.	{ EYE INFIRMARY, Operations, 12 M. CITY HOSPITAL, Medicine, Dr. Bulkley, half-past 1 P.M. BELLEVUE, Surgery, Dr. Sayre, half-past 1 P.M.
Thursday, July 26.	{ OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M. CITY HOSPITAL, Surgery, Dr. Watson, half-past 1 P.M. BELLEVUE, Medicine, Dr. Loomis, half-past 1 P.M.
Friday, July 27.	{ CITY HOSPITAL, Surgery, Dr. Parker, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M. BELLEVUE, Surgery, Dr. Church, half-past 1 P.M.
Saturday, July 28.	{ OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M. CITY HOSPITAL, Medicine, Dr. Bulkley, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M.

**At a meeting of the Kings' County**

Medical Society the following resolutions were passed:—

Whereas, By the inscrutable ordering of Divine will, our loved and honored associate, Dr. Charles E. Isaacs, has been taken from us in the prime of his life and usefulness; and

Whereas, We deplore such a loss as one of the greatest which could befall us. It is hereby

Resolved, That not only this Society but the whole community have cause to mourn his death as of one in whom were combined in a remarkable degree the highest order of professional attainment, with social and personal qualities the most genial and endearing.

Resolved, That as an anatomist he had no superior. That in his celebrated and original paper on the Microscopic Anatomy of the Kidney, he erected an imperishable monument to his own renown, as well as to the honor of his profession and his country.

Resolved, That as a Surgeon and Physician he had by his skill and industry won the unqualified respect and admiration of his professional brethren, and endeared himself to his patients by his unwearied and unselfish devotion to their interests.

Resolved, That we honor his memory as that of an accomplished Physician, an honorable gentleman, and an humble Christian.

Resolved, That a copy of these resolutions be sent to the relatives of the deceased, and put on the records of this Society.

## Paul Bossange, Importer of Specimens of Osteology,

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## Oak Orchard Acid Spring.—Letter from J. H. ARMSBY, M. D.

ALBANY HOSPITAL, May 24th, 1860.

MR. OLCOTT.

Dear Sir:—I have used the "Oak Orchard Mineral Water" quite extensively during the past Winter, in private practice and in the Hospital.

My first patient had a large Phagedenic Ulcer, extending from the hip to the knee. The water was administered in tablespoonful doses four times daily, and the ulcer was covered with lint saturated in the water twice daily. The improvement was most decided and marked from the first day of its use, while the usual remedies had produced very little effect. In about five weeks from the commencement of the treatment he left the hospital nearly well, and resumed his ordinary business.

In several other cases, which I propose to notice hereafter, the water was found to be very efficacious.

The diseases in which I have found it most useful are as follow:—Ill-conditioned Ulcers—Diseases of the Skin—Passive Hemorrhages—Diarrheas depending on an atonic condition of the mucous membranes. In depraved and impoverished conditions of the body from *specific disease* and from intemperance.

I have used it with great advantage in Hemorrhoids, Fistula in Ano and Perine, Hemorrhages from the rectum, and in several other forms of disease.

In my opinion, and in my practice, it has fully sustained the reputation it has acquired as a remedial agent and the remarkable properties as a tonic and astringent indicated in its chemical analysis. I propose to give it an impartial and extensive trial, and will give you my results so far as they may be of value.

I have the honor to be, very respectfully, yours,

J. H. ARMSBY, M. D.

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Dealers supplied on liberal terms.

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## ANNOUNCEMENT.

In presenting the first number of the **American Medical Times**, to the subscribers to the **New York Journal of Medicine**, the Publishers particularly call attention to the fact that it is the continuation in a weekly series of that periodical, which ceased as a bi-monthly with the May number.

For an explanation of the motives which have led to the alteration in the form and issue of the Journal we refer to the leading editorial in the present number.

The publishers have much pleasure in stating that STEPHEN SMITH, M.D., will retain the position of Editor, with whom will be associated ELISHA HARRIS, M.D., and GEORGE F. SHRADY, M.D., who will devote themselves to the respective departments in which they are already known to the profession. Ample facilities are provided for reporting Lectures, Hospital Practice, Transactions of Societies, etc. Each number will consist of Twenty-four quarto pages, double columns, and contain Lectures, Original Communications, Reports of Hospitals, Editorial Articles, Reviews, Reports of Societies, etc., etc.

**TERMS.**—To City Subscribers and in the British Provinces, \$3 50; Mail Subscribers, \$3 00. This Journal now affords, at the same price, nearly three times the reading matter of the former series.

The NEW YORK MEDICAL PRESS was discontinued with the close of its last volume (June 30), and its subscription list transferred to this periodical. The Medical Times will be sent to those subscribers to the Journal of Medicine, and the Medical Press, who have paid in advance, until their respective subscriptions expire. Subscribers to these periodicals who are in arrears, must pay all such arrearages, and renew their subscriptions to this Journal, or it will not be sent to them.

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\* \* Hereafter the rule of payment in advance will be rigidly adhered to, and all who desire to become subscribers to the Medical Times must transmit the money with their orders.



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Department. Session, 1860-61.  
The Session for '60-61 will begin on Monday, October 15, and will be continued until the 1st of March.

## FACULTY OF MEDICINE.

REV. ISAAC FERRELL, D.D., LL.D., Chancellor of the University.  
VALENTINE MOTT, M.D., LL.D., Emeritus Professor of Surgery and Surgical Anatomy, and Ex-President of the Faculty.  
MARTIN PAINE, M.D., LL.D., Professor of Materia Medica and Therapeutics.  
GUNNING S. BEDFORD, M.D., Professor of Obstetrics, the Diseases of Women and Children, and Clinical Midwifery.  
JOHN W. DRAPER, M.D., LL.D., Professor of Chemistry and Physiology, President of the Faculty.  
ALFRED C. POST, M.D., Professor of the Principles and Operations of Surgery, with Surgical and Pathological Anatomy.  
WILLIAM H. VAN BUREN, M.D., Professor of General and Descriptive Anatomy.  
JOHN T. METCALFE, M.D., Professor of the Institutes and Practice of Medicine.  
J. W. S. GOULEY, M.D., Demonstrator of Anatomy.  
J. H. HUNTON, M.D., Professor to the Professor of Surgery.  
ALEXANDER B. MOTT, M.D., Professor to the Emeritus Professor of Surgery.

Besides daily Lectures on the foregoing subjects, there will be five Cliniques, weekly, on *Medicine, Surgery, and Obstetrics*.  
The Dissecting-Room, which is refitted and abundantly lighted with gas, is open from 8 o'clock, A.M., to 10 o'clock, P.M.  
Fees for a full Course of Lectures, \$105; Matriculation fee, \$5; Graduation fee, \$30; Demonstrator's fee, \$5.

**Medical Institution of Yale College.**

The Course of Lectures for 1860-61 will commence on Thursday, September 13th, and continue four months.

BENJAMIN SILLIMAN, M.D., LL.D., Prof. Emeritus of Chemistry and Pharmacy.  
ELI IVES, M.D., Prof. Emeritus of Materia and Therapeutics.  
JONATHAN KNIGHT, M.D., Professor of the Principles and Practice of Surgery.  
CHARLES HOOKER, M.D., Professor of Anatomy and Physiology.  
WORTHINGTON HOOKER, M.D., Professor of the Theory and Practice of Physic.  
BENJAMIN SILLIMAN, JR., M.D., Prof. of Chemistry and Pharmacy.  
PLINY A. JEWETT, M.D., Prof. of Obstetrics.  
CHARLES A. LINDSEY, M.D., Prof. of Materia Medica and Therapeutics.

LECTURE FEES, \$68 50. Matriculation, \$5. Graduation, \$15.

CHARLES HOOKER, *Dean of the Faculty.*

NEW HAVEN, May, 1860.

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LEWIS A. SAYER, M.D.,  
STEPHEN SMITH, M.D.

Wade and Ford beg leave to call the attention of the faculty to the following notice of this Case of Instruments in the May number of the New York Journal of Medicine, page 427:

"A NEW AND COMPLETE CASE OF SURGICAL INSTRUMENTS.—The practitioner of surgery not unfrequently has need of an operating case which, in a compact form, embraces the instruments necessary for any and all operations. To the country practitioner especially, would a case of instruments thus selected, be a valuable acquisition. Such an operating case has recently been prepared by Messrs. Wade and Ford, 85 Fulton Street, New York, under the direction of Dr. James R. Wood, combining in a single case of moderate dimensions, instruments and apparatus adapted to every emergency in which a surgeon can be placed."

We have recently perfected Dr. Lewis A. Sayer's improved instrument for Morbus Coxarius, under his directions, and will, if requested, forward directions for measurements necessary for a perfect fit.

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During the thirteen years which this mechanism has been so generally sought for and used by more than four thousand persons, it has been thoroughly tested and proved by the very best, most intelligent, critical, and experienced judges, to be all that is claimed for it in naturalness, elasticity, lightness, strength, utility, reliability, and the greatest durability, and to possess every quality and action essential and desirable in an artificial limb, to render it a perfect counterpart to the natural limb in every place, position, and vocation, in sitting, standing, walking, or laboring. Every class, age, and sex of the community is represented in the use of this limb, in the greatest usefulness, pride, comfort, and satisfaction, including those of the most laborious lives.

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